FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

New York State

State/Territory: _____
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

_____
(Signature of Agency Head)

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Developed by the National Academy for State Health Policy

SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

New York State estimates that 540,000 children in this state, living in households with net incomes below 192% of federal poverty level, are without health insurance. Most recently this estimate was reported in the State Children's Health Insurance Program Annual Report for the period April 15, 1998 through September 30, 1998.

1.1.1 What are the data source(s) and methodology used to make this estimate?

The estimate of 540,000 uninsured children in New York State represents an average of the two most recent Current Population Surveys (CPS) available as of March 1998. An average was used to offset irregular patterns in the data. Using the Census Bureaus definition of the uninsured and its procedure for expressing family income as a percentage of the poverty level, we analyzed the CPS data for New York State for calendar years 1996 and 1997. These years represent the time period immediately preceding New York's implementation of SCHIP in April 1998.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

While we chose to define the baseline population using the CPS, we are aware of reliability problems and definitional issues associated with these measures. As recognized by Congress, even three-year averages from the CPS vary widely over time. In light of the substantial fluctuations seen in CPS estimates of the uninsured, we have to suspect that both sampling and non-sampling errors are coloring the results in ways that are not readily quantified.

In addition, the CPS definition of the uninsured as those without insurance for the entire year, is of limited utility in evaluating a program where eligibility is based on being uninsured at any time during the year. Based on the Census Bureau's Survey of Income and Program Participation and other sources, we might expect that the number of children uninsured at a point-in time range from 1.3 to 1.9 times the number of uninsured all year. Indeed, with guaranteed eligibility, a more relevant measure would be the number of children who are uninsured at any time over the course of the year. Other surveys suggest that number may be from 1.6 to 2.8 times the number of uninsured all year. Reliable estimates of the dynamics of eligibility are simply not available.

These problems are not unique to New York State. They affect any state's baseline estimates derived from the CPS. Like other states, we hope the efforts funded under the just-enacted Balanced Budget Refinement Act of 1999 will address the problems and improve our ability to target and evaluate our programs.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

New York State has been a leader in taking steps to increase the number of children with creditable health coverage. Since receiving approval under Title XXI on April 15, 1998, enrollment in New York's Child Health Plus (CHPlus) program has grown by 122 percent. Program enrollment was approximately 175,000 children in March of 1998, and reached nearly 389,000 by September 30, 1999. Given the number of children currently enrolled and that program enrollment has more than doubled in the past 18 months, we feel that great progress has been made in increasing the number of children with creditable health coverage. This progress has undoubtedly been hastened with the additional funding available through Title XXI.

1.2.1 What are the data source(s) and methodology used to make this estimate?

New York's CHPlus program currently contracts with 32 insurers to provide comprehensive health insurance coverage to nearly 389,000 children as of September 30, 1999. Each insurer is required to submit monthly data files to the Department to support the monthly premiums paid for this insurance coverage. Using these data files, the Department has developed an extensive database of enrollee specific information. This database is queried monthly to determine the number of children enrolled as well as their demographic characteristics such as county of residence, and subsidy level.

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Each insurer's data submission is subject to an edit process to ensure reliability and accuracy. In addition, annual audits are conducted on each insurer to check for adherence to program procedures such as eligibility determination and data submissions. Because of these checks on insurer operations we feel our data systems are reliable and can state with confidence that great progress has been made in New York State over the past 18 months at increasing the number of children with creditable health coverage.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

As specified in our state plan, a primary goal of the CHPlus program is to reduce the number of uninsured children in New York State. With successful outreach strategies and a

commitment from federal and state government, this goal is being realized. Despite the program's existence prior to the enactment of Title XXI, CHPlus enrollment has grown by over 122 percent since New York received approval to participate in April of 1998. Although the increase in the number of children enrolled in CHPlus has been steady over the past 18 months, there are still children in the state without health insurance. Unfortunately the level of uninsurance is difficult to measure because of the time lag with data collection and reporting. Therefore, the only method we can use to accurately assess achievement of our primary goal is to look at the increase in children enrolled in CHPlus. As stated previously, the total number of children covered under CHPlus has increased from approximately 175,000 at the end of March 1998, to nearly 389,000 by September 30, 1999.

A second goal of the CHPlus program is to ensure the program is accessible and families have knowledge of its availability. Outreach is conducted statewide to provide knowledge about the program through marketing mediums such as television commercials, radio spots, health fairs and billboards. Records of toll free hotline activity and inventories of promotional materials are reviewed on a monthly basis to provide program staff with feedback on outreach effectiveness. To ensure accessibility to providers, each insurer under contract to the Department is subjected to regular provider network reviews. Each network is reviewed for proximity within the approved service areas of each insurer. Program staff works with each insurance plan to ensure program accessibility throughout their regions.

To further program accessibility the Department is implementing a facilitated enrollment program in the coming months. This initiative was developed to simplify and coordinate enrollment in children's health insurance. Facilitated enrollment is a simplified, user-friendly method of applying for the CHPlus and Medicaid Programs. Facilitated enrollers will be located in community-settings such as schools, libraries, clinics, community centers and churches and will be available during non-traditional hours including evenings and weekends. They will assist families in completing the "Growing Up Healthy" application, the common application for CHPlus, Medicaid and the Special Supplemental Food Program for Women Infants and Children (WIC). Facilitated enrollers will screen families to determine which program the child appears eligible for, conduct the face-to-face-interview required for Medicaid, assist families in collecting required documentation and in selecting a managed care organization. The Local Department of Social Services (LDSS) office or CHPlus health plan will continue to perform the final eligibility determination. This model will help assure that children are enrolled in the correct program.

A Request for Proposals (RFP) was issued for organizations to perform facilitated enrollment. As a result, thirty-four organizations were selected. In addition, multiple organizations that have experience working with the target community will be subcontracting with the successful grantees. Funding for this initiative is $10 million for a one-year period and will provide facilitated enrollment on a statewide basis. A training contractor has also been selected to conduct the initial training and provide ongoing technical support for facilitated enrollers. Training is currently underway.

Perhaps one of the most important outcome goals of any public insurance program is to improve health status. In New York State, all managed care organizations are required to report

annually, to the Department certain quality and effectiveness of care measures. These measures are collected separately for Commercial, Medicaid and CHPlus populations. The outcome measures most appropriate for children include immunizations, lead and tobacco screenings, well-child visits and alcohol abuse counseling sessions. These measures were first collected for the CHPlus population during 1998. The fact that many children move in and out of public health insurance makes it difficult to capture longitudinal effectiveness of care measures such as immunizations during the first 2 years of life. However, results indicate that the CHPlus population is nearly identical to the Medicaid and Commercial populations for most measures collected.

Table 1.3		
(1) Strategic Objectives	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress**
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Provide access to inpatient, outpatient, primary and preventive health care services to low income children by removing financial barriers and providing a medical home through a managed care product.	Reduce the number of uninsured children in the State.	Data Sources: CHPlus enrollment; Current Population Survey (CPS) Methodology: Assessment of CHPlus monthly enrollment reports from contractors. Numerator: Number of children enrolled in CHPlus Denominator: Number of uninsured children with net household incomes between 100% and 192% of federal poverty level. Progress Summary: Enrollment in CHPlus has increased dramatically over the past 18 months. Program enrollment data show that nearly 214,000 more children are covered under CHPlus since New York State received approval of their Title XXI state plan. Current Population Survey data is the primary means for assessing the progress in reducing the uninsured. It is difficult to use this database because of the time lag between collection and reporting. The CPS data we have received to date actually reflects the state of uninsurance prior to New York's approval to participate in Title XXI. We expect next year's CPS data to be useful in determining the change in uninsurance status of children in New York State.

Table 1.3		
(1) Strategic Objectives	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress**
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Provide access to inpatient, outpatient, primary and preventive health care services to low income children by removing financial barriers and providing a medical home through a managed care product.	Program is accessible to all families with qualified, uninsured children and having a knowledge of program availability	Data Sources: Statewide outreach, County enrollment figures, Hotline call monitoring. Methodology: N/A Numerator: N/A Denominator: N/A Progress Summary: Outreach efforts are conducted statewide. To evaluate the effectiveness of these efforts, county level enrollment data is analyzed and compared to activity in specific markets. Comparing these databases show that the media campaigns have been successful in reaching those children in need of health insurance. Hotline call records show a steady level of activity, also indicating a high level of effectiveness at reaching out to the population that may be eligible.

N/A – Not Applicable

Table 1.3		
(1) Strategic Objectives	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress**
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Provide access to inpatient outpatient, primary and preventive health care services to low income children by removing financial barriers and providing a medical home through a managed care product.	Children have better health care status.	Data Sources: NYS Quality Assurance Reporting Requirement data: Number of immunizations, well child visits, lead and tobacco screening, adolescent well visits, patient satisfaction. Methodology: Rates of specific measures based on data reported by each insurer for children insured over a continuous 12 month period increase. Numerator: Number of visits, immunizations and screenings. Denominator: Number of children enrolled during a continuous 12 month period. Progress Summary: The effectiveness of care measures collected for 1998 show the CHPlus population is nearly identical to both the Commercial and Medicaid populations for immunizations, lead and tobacco screening, well child visits and alcohol abuse counseling. The effectiveness of care data for 1999 is currently being collected.

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

Title XXI funding is used, in combination with state funds, for the Child Health Plus (CHPlus) program and for the expansion of benefits under the State's Medicaid plan. Child Health Plus serves children at or below age 19, with a net household income at or below 192% of the federal poverty level, who are not eligible for Medicaid. Federal funds were first used in this program effective April 15, 1998, following approval of the state plan. In addition to CHPlus, Title XXI funding is used for medical assistance benefits for children ages 15 through 18 years in families with net incomes at or below 100% of the federal poverty level who were not previously eligible for Medicaid as of March 31, 1997. This optional provision under Title XXI was implemented in New York State on January 1, 1999.

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

N/A

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

N/A

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

New York State's SCHIP program was born out of a long-standing state-only program, CHPlus, originally implemented in 1990. That program was the basis for the current efforts that provide subsidized health insurance to nearly 389,000 low-income children. CHPlus provided a strong foundation for continued improvements to the program and enabled a rapid increase in enrollment following the implementation of Title XXI. The pioneering efforts of New York, in establishing a publicly sponsored health insurance program for low-income children, were also examined by many other states in the design of their SCHIP programs.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

As mentioned above, the pre-existing Astate-only@ Child Health Plus program was well established prior to Title XXI implementation. That program has been continued and expanded since that time. The infusion of federal funding through Title XXI allowed for the selection of additional participating insurers, expansion of benefits, increased eligibility and improvements in the ability to effectively increase marketing and outreach efforts.

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Child Health Plus

One of the more significant changes in the State, since implementation of Title XXI, has been the public awareness of the program. With the implementation of Title XXI came a tremendous amount of media attention, on both a state and national level. This media attention and corresponding increases in advertisements resulted in a greater public inquiry into the program. Not only were consumers more aware of the program, government officials also recognized the tremendous benefits available for children through Title XXI. In 1998 the Governor and New York State legislature amended the Public Health Law to significantly expand the existing CHPlus program. This legislation added a number of benefits to the standardized package including inpatient mental health, alcohol and substance abuse services; emergency, preventive and routine dental care; vision, speech and hearing services; durable medical equipment; and coverage for non-prescription drugs. In addition, all co-payments and coinsurance for covered services were eliminated and eligibility levels were expanded. The family contributions were reduced for children with family incomes below 133 percent of the federal poverty level. Statutory changes also mandated an increase in marketing and outreach efforts. Effective marketing activities have included Department of Motor Vehicle inserts, billboards, extensive television and radio advertisements, a presence at numerous health fairs, and distribution of promotional items and brochures statewide.

Other changes that have occurred since Title XXI is the development of a facilitated enrollment program to increase the number of children enrolled in both CHPlus and Medicaid. The facilitated enrollment program is a joint effort between the state and community based organizations to reach out to more uninsured children and provide them with access to quality, affordable health care services.

Medicaid

In addition to the CHPlus program changes in 1998, Medicaid program eligibility was expanded. New York State exercised the option provided in Title XXI of accelerating medical assistance eligibility for children ages 15 through 18 years. This effort provided increased access to affordable health care services to New York's children. Along with Medicaid provisions in Title XXI, changes to New York's public health law in 1998 allowed existing Medicaid managed care providers to also participate in CHPlus. This furthered the state's effort to provide a seamless system of health coverage for all of New York's children.

Shortly before Title XXI was enacted, New York's Partnership Plan (Federal Section 1115 Demonstration project) was approved for a five-year period to begin July 1997. The program's mission is to improve access to comprehensive health care for Medicaid recipients through mandatory enrollment in managed care systems and contain Medicaid costs through increase efficiency. These changes impact children and adults covered by Medicaid and have broad ramifications for the uninsured and the providers which have traditionally served them. In 1999, the Health Care Financing Administration (HCFA) authorized state and city health officials to begin mandatory managed care enrollment for the Medicaid population in portions of New York City. Beneficiaries are allowed to choose a managed care plan or may elect to be automatically assigned to a plan. Establishing primary care providers for Medicaid beneficiaries will lead to an increase in the availability of affordable, quality health care services and ultimately improved health status.

In addition to the changes described above, in 1998 the governor and legislature signed into law an expansion of Medicid eligibility for children. The implementation of this expansion is contingent on the earlier of one of two events happening. One event is the securing of all federal approvals necessary to enroll children eligible for Medicaid under this expansion in a Medicaid managed care program. The second event that could trigger this expansion is that the Commissioner of the Department of Health certifies that at least 50 percent of persons eligible to enroll in Medicaid under the Partnership Plan are enrolled in such programs. When the expansion is implemented, Medicaid presumptive eligibility will be available.

Private Insurance

In recent years, nationwide studies have shown that many employers have either eliminated health insurance coverage or dramatically increased the share of employee contributions toward the cost of their health insurance. These realities have prompted New York officials to reach beyond public insurance programs and develop initiatives in the private health insurance market. The existing New York State Small Business Health Insurance Partnership Program (NYSHIPP) assists eligible (gross household income below 222%FPL) employers and sole proprietors without employees in purchasing small group health insurance policies for their full-time employees and dependents. The State subsidizes the health insurance premiums of approved businesses up to 45% of their cost.

In 1998, a Request for Proposals were issued for the Voucher Insurance Program. This demonstration program, implemented in two counties, provides financial assistance, in the form of vouchers, to eligible individuals to purchase health care coverage from one of three participating insurers. The purpose of the program is to determine if access to a primary care provider reduces inappropriate emergency room use.

Through both public and private insurance initiatives, New York has shown a commitment to reducing the number of uninsured individuals. These efforts will undoubtedly lead to increased access to quality, affordable health care services and ultimately improve the health status of all persons in the state.

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

The criteria that must be met for a child to be eligible for the benefits available under the CHPlus program are the following:

- Below 19 years of age
- Resident of New York State
- Not eligible for Medicaid
- No access to a state health benefits plan
- No equivalent insurance

To be eligible for a subsidy, those children who meet the criteria listed above, must live in a household with a net income at or below 192% of federal poverty. Eligibility for Medicaid follows the standard criteria under Title XIX. To be eligible for benefits under the Medicaid expansion option of Title XXI, applicants must be between the ages of 15 and 19 and not previously eligible for medical assistance benefits. Medicaid income eligibility is at or below 100% of net income. All Medicaid applicants must also present proof of citizenship or "qualified alien" status to qualify for services.

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

At the time of application for Child Health Plus or Medicaid, individuals must present documentation that proves the eligibility standards have been met. The standards for eligibility and acceptable documents to prove each standard are the following:

- date-of-birth – birth certificate; school records
- residency – utility bill; postmarked envelope indicating address; rent receipt
- income - four consecutive, recent pay stubs or most recent federal or state tax return; documentation from employer

For Medicaid program eligibility, applicants must also prove citizenship or "qualified" alien status.

Table 3.1.1		
	Medicaid CHIP Expansion Program	**State-designed CHIP Program "Child Health Plus"**
Geographic area served by the plan	Statewide	Statewide
Age	15 – 19 years	Under the age 19
Income	< 100% federal poverty level	100 – 192% federal poverty level
Resources	N/A	N/A
Residency requirements	Must be State resident	Must be State resident
Disability status	N/A	N/A
Access to or coverage under other health coverage		May not be covered at time of application
Citizenship	Yes or "qualified" alien status	N/A

3.1.2 How often is eligibility redetermined?

Child Health Plus program enrollees are screened for eligibility once every 12 months. Insurers are responsible for collecting and evaluating the required documentation that determines a child's eligibility. Enrolled children receive a notice 60 days prior to the end of their 12th month of enrollment. This notice describes the redetermination process, includes the application for redetermination and indicates the documents that must be supplied to the insurer in order for the child to remain enrolled in the program. Once the redetermination process is complete and approved by the insurance plan, CHPlus insurance coverage continues.

Eligibility for Medicaid services is re-determined every 12 months. All applicants must present the required documentation to their Local Department of Social Services (LDSS) office for final eligibility determination.

Table 3.1.2		
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program
Monthly		
Every six months		
Every twelve months	X	X
Other (specify)		

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

There is no guaranteed period of time a participant is eligible for Child Health Plus program benefits. If the household income changes, it is the family's responsibility to report that change within 60 days to the insurer. Similarly, any change in residency or equivalent insurance status must be reported to the insurer.

Under recently enacted state law, as of January 1, 1999, all Medicaid eligible children are guaranteed to receive program benefits for 12 months. Following the 12 month period, each enrollee must present the required documentation to re-qualify them for eligibility to the LDSS office.

3.1.4 Does the CHIP program provide retroactive eligibility?

There is no retroactive eligibility for CHPlus. Under Medicaid program policy, eligibility is effective the first day of the month of application. Therefore, if a final eligibility determination is made at any time following application, the effective date for service coverage is retroactive back to the first day of the month the application was filed with the LDSS office. If a person can document they have unpaid or recently paid medical expenses within 90 days prior to the month of eligibility, those expenses may be paid by Medicaid.

3.1.5 Does the CHIP program have presumptive eligibility?

CHPlus program applicants are allowed a one-time presumptive eligibility period of 60 days. If an application is submitted without the essential documentation that enables a final eligibility determination, the applicant is presumptively enrolled for 60 days. The applicant is then allowed 60 days within which to produce the necessary documents.

The Medicaid program does not have a presumptive eligibility policy. All necessary documentation must be complete and accompany the application before a final eligibility determination can be made. However, the effective date of coverage will go back to the first day of the month of application. In 1999, New York State enacted legislation to provide Medicaid presumptive eligibility at a point in the future that will coincide with an expansion of Medicaid eligibility.

3.1.6 Do your Medicaid program and CHIP program have a joint application?

In order to further the efforts of a seamless system of health care coverage for all children, a joint application has been developed for CHPlus, Medicaid and the Special Supplemental Food Program for Women, Infants and Children (WIC). This application,

called “Growing Up Healthy”, is a result of a collaborative effort between the Department of Health, advocacy organizations and health plans.

The “Growing Up Healthy” application was developed and pilot tested in various locations throughout the State. These pilot projects served a dual purpose. First, pilot sites provided valuable feedback on the design and utility of the application itself. Second, the pilots demonstrated the process of providing application assistance, which became the model for the Facilitated Enrollment. As a result of the pilots, the “Growing Up Healthy” application has been redesigned to be more user-friendly, and will be used as the standard application statewide.

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

One of the strengths of the eligibility determination process for CHPlus is the ease with which children apply for program enrollment. Each insurer accepts applications through the mail or in person. This policy has greatly increased the number of low-income children enrolled in the program who now have creditable health coverage.

Another strength of the CHPlus program eligibility determination is presumptive eligibility. If a family applies to the program and appears eligible but is missing one or more pieces of documentation in support of the application, the child can be presumptively enrolled for a 60 day period. The family must provide the required documentation within that 60 day period or the child will be disenrolled from the program. This feature has allowed many individuals to enroll in the program more quickly than if they needed to have all documentation at the time of application.

Facilitated enrollment is a user-friendly method of applying for either CHPlus, Medicaid or the Special Supplemental Food Program for Women, Infants and Children (WIC). Under this program, culturally and linguistically appropriate enrollers will be located in community settings during non-traditional hours such as evenings and weekends. They will assist families in completing the “Growing Up Healthy” application, the joint application for CHPlus, Medicaid and WIC. The enroller will perform a screen to determine which program the child appears eligible for and will help the family collect the documentation required for that program. If the child appears Medicaid eligible, the enroller will complete the face-to-face interview required for Medicaid so the family won’t need to go to the LDSS to apply. The enroller will also educate the family about managed care and assist them in selecting a health plan.

One of the primary goals of the facilitated enrollment initiative is to ensure that children enroll in the insurance program they are eligible for. By making the application process more user-friendly and convenient for families, while removing some of the barriers associated with the Medicaid application process, children will enroll in the program they are eligible for. Use of the simplified joint application will also make the application process less complicated for families.

3.1.8 Evaluate the strengths and weaknesses of your eligibility redetermination process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

The CHPlus eligibility re-determination process is done on an annual basis. By doing so, health plans can ensure that children continue to meet program eligibility standards so that federal and state dollars are being spent appropriately. As with the initial application process, program recertification is conducted through the mail. Health plans are required to notify enrollees that they are scheduled to recertify at least 60 days prior to the end of their 12-month period of eligibility. The application may be shorter for purposes of recertification than the initial application.

Currently, about 30 percent of children fail to recertify for CHPlus coverage. The reasons families fail to recertify in the program vary. Some families no longer need coverage because they receive insurance through an employer. Others may become Medicaid eligible and some may move out of the state. There are also families that are confused by the recertification process and may not understand that re-application is necessary. Health plans currently attempt to follow-up with families by phone and through the mail to encourage them to recertify.

Facilitated enrollment will attempt to improve the recertification rate by assisting families with the process. Facilitated enrollers will not only be assisting families to enroll new children but will also assist with recertifications. Enrollers will be reaching out to families scheduled to recertify for CHPlus to assist them in completing the process. They will be helping families complete the application and collect required documentation. By ensuring that the recertification application and supporting documentation are submitted to the health plan in a timely manner, the child will not experience a lapse in coverage and therefore need to reapply to the program.

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

New York's CHPlus program provides a comprehensive benefit package for all children enrolled. From the program's inception in 1992 covering only outpatient services, many improvements to the benefit package have been made. Current program benefits include inpatient and outpatient hospital services; well-child visits; inpatient and outpatient mental health and alcohol and substance abuse services; ambulatory surgery; diagnostic and laboratory tests; durable medical equipment; therapeutic services; speech and hearing; home health care services; prescription and non-prescription drugs; emergency medical services; emergency, preventive and routine vision care; emergency, preventive and routine dental care.

The Medicaid benefits package is comprehensive and focuses on services related to primary, preventive, inpatient and emergency care. Currently, program benefits include inpatient and outpatient hospital care; physician services; home health services; emergency room; FQHC and clinic services; vision; limited hospice; mental health care; laboratory and diagnostic services; radiology; private duty nursing; durable medical equipment; and prosthetic/orthotic supplies.

The delivery system for CHPlus and the Medicaid managed care program includes a network of managed care providers within each insurance plan under contract to the State. Each network of primary care providers and specialists coordinate the health care needs of enrolled children and render necessary services.

3.2.1 Benefits

The benefits and related information are listed in the table below.

Table 3.2.1 CHIP Program Type Child Health Plus			
Benefit	Is Service Covered?	Cost-Sharing	Benefit Limits
Inpatient hospital services	Yes	NA	*
Emergency hospital services	Yes	NA	*
Outpatient hospital services	Yes	NA	
Physician services	Yes	NA	
Clinic services	Yes	NA	
Prescription drugs	Yes	NA	May be limited to generic medications.
Over-the-counter medications	Yes	NA	Authorized by a professional licensed to write prescriptions.
Outpatient laboratory and radiology services	Yes	NA	
Prenatal care	Yes	NA	
Family planning services	Yes	NA	
Inpatient mental health services	Yes	NA	Combined 30 days per calendar year for inpatient mental health and substance abuse treatment.
Outpatient mental health services	Yes	NA	Maximum of 60 days per year for outpatient mental health and substance abuse services.
Inpatient substance abuse treatment services	Yes	NA	A combined 30 days per calendar year.
Residential substance abuse treatment services	Yes	NA	Combined 30 days per calendar year for inpatient mental health and substance abuse treatment.
Outpatient substance abuse treatment services	Yes	NA	A maximum of 60 days per year for outpatient mental health and substance abuse services.
Durable medical equipment	Yes	NA	No coverage for cranial prostheses or dental prostheses. If dental prostheses are needed as the result of accidental injury, congenial abnormality, or reconstructive surgery it is covered.
Disposable medical supplies	Yes	NA	Must be prescribed by a physician or other licensed health care provider.
Preventive dental services	Yes	NA	

Table 3.2.1 CHIP Program Type Child Health Plus			
Benefit	Is Service Covered?	Cost-Sharing	Benefit Limits
Restorative dental services	Yes	NA	
Hearing screening	Yes	NA	
Hearing aids	Yes	NA	
Vision screening	Yes	NA	
Corrective lenses (including eyeglasses)	Yes	NA	
Developmental assessment	Yes	NA	
Immunizations	Yes	NA	
Well-baby visits	Yes	NA	In accordance with visitation schedule established by American Academy of Pediatrics.
Well-child visits	Yes	NA	In accordance with visitation schedule established by American Academy of Pediatrics.
Physical therapy	Yes	NA	Short term
Speech therapy	Yes	NA	Condition must be amenable to significant clinical improvement within a two month period.
Occupational therapy	Yes	NA	Short term
Physical rehabilitation services	Yes	NA	
Podiatric services	Yes	NA	
Chiropractic services	No	NA	
Transportation	No	NA	
Home health services	Yes	NA	Minimum of 40 visits per calendar year, if such visits are medically necessary and in lieu of hospitalization.
Skilled Nursing facility	No	NA	
ICF/MR	No	NA	
Hospice care	No	NA	
Private duty nursing	No	NA	
Personal care services	Yes	NA	

Table 3.2.1 CHIP Program Type Child Health Plus			
Benefit	Is Service Covered?	Cost-Sharing	Benefit Limits
Rehabilitation facility	No	NA	
Case management/Care coordination	No	NA	
Non-emergency transportation	No	NA	
Interpreter services	No	NA	
Orthodontics	No	NA	
Experimental medical or surgical procedures	No	**NA**	
Experimental drugs	No	NA	
Cosmetic, plastic, or reconstructive surgery	No	NA	
Infertility services	No	NA	
Personal or comfort items	No	NA	
Services that are not medically necessary	No	NA	
Second surgical opinion	Yes	NA	
Second medical opinion	Yes	NA	
Pre-surgical testing	Yes	NA	If ordered by physician and surgery takes place within 7 days of testing.

* Medically Necessary

Table 3.2.1 CHIP Program Type Medicaid			
Benefit	Is Service Covered?	Cost-Sharing	Benefit Limits
Inpatient Hospital Services	Yes	NA	*
Professional Ambulatory Services	Yes	NA	*
Preventive Health Services	Yes	NA	
Laboratory Services	Yes	NA	*
Radiology Services	Yes	NA	*
EPSDT Services/Child Teen Health Program (C/THP)	Yes	NA	
Home Health Services	Yes	NA	*
Private Duty Nursing Services	Yes	NA	*
Emergency Room Services	Yes	NA	
Foot Care Services	Yes	NA	*
Eye Care and Low Vision Services	Yes	NA	*
Durable Medical equipment (DME)	Yes	NA	* disposable medical supplies and enteral formula excluded
Hearing Aids Services	Yes	NA	*
Family Planning Reproductive Health Services	Yes	NA	
Transportation Services	Yes	NA	
Dental Services	Yes	NA	
Court-Ordered Services	Yes	NA	

Table 3.2.1 CHIP Program Type Medicaid			
Benefit	Is Service Covered?	Cost-Sharing	Benefit Limits
Prosthetic/Orthotic Services/Orthopedic Footwear	Yes	NA	*
Mental Health Services	Yes	NA	*
Alcohol and Substance Abuse Services (ASA)	Yes	NA	*
Experimental and/or Investigational Treatment	Yes	NA	Case by case basis in accordance with the provisions of Section 4910 of the New York State Public Health Law
Detoxification Services	Yes	NA	*

* Medically Necessary

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

The scope and range of coverage for health benefits offered under Child Health Plus and Medicaid are presented in Appendix A and B of this report.

3.2.3 Delivery System

New York State is comprised of 62 counties. Insurance plans must be licensed in each county where they conduct business. Insurance plans with a license in a county to conduct Commercial or Medicaid managed care, are permitted to conduct CHPlus in that county. Currently, there are 32 managed care organizations that participate in CHPlus and 36 managed care organizations that participate in the Medicaid managed care program.

Table 3.2.3

Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program "Child Health Plus"
A. Comprehensive risk managed care organizations (MCOs)		
Statewide?	**Yes**	Yes
Mandatory enrollment?	No	No
Number of MCOs	36	32
B. Primary care case management (PCCM) program	Yes	Yes
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision	Yes	Yes
D. Indemnity/fee-for-service	Yes	Yes

3.3 How much does CHIP cost families?

CHPlus program is a low-cost or no-cost program for low-income uninsured children. During calendar year 1998, nominal co-payments were required for some services. In addition, a $5 fee was assessed for failure to notify an insurer within 24 hours of emergency room use and a $10 fee charged for inappropriate use of the emergency room. Small premium contributions were required of families depending on income. Families with net incomes below 133% of federal poverty were required to contribute $9 per child per month, up to a family maximum of $36 per month. Families with net incomes between 133% and 185% of federal poverty contributed $13 per child per month, up to a family maximum of $52 per month.

Effective January 1, 1999, all co-payments and additional fees for visits were eliminated. Program eligibility was expanded along with changes to the family contribution amounts. Premium contributions are no longer required for families with a household net income below 133% of federal poverty. For those families with net incomes between 133% and 185% of federal poverty, they are required to contribute $9 per month per child, up to a family maximum of $27 per month. Families with incomes between 186% and 192% of federal poverty pay $15 per month per child, up to a family maximum of $45 per month. Under the SCHIP Medicaid expansion option program, there are no copayments, deductibles or premium contributions.

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/
copayments, or other out-of-pocket expenses paid by the family.)

___ No, skip to section 3.4

_X_ Yes, check all that apply in Table 3.3.1

Table 3.3.1		
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program
Premiums		**X**
Enrollment fee		
Deductibles		
Coinsurance/copayments**		
Other (specify) _____		

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

As noted above, for CHPlus enrollees there are nominal premium contributions required of families with net incomes greater than 133% of federal poverty. Participating insurers collect premium contributions on a monthly basis. These contributions offset the total premium amount paid by the State to each insurer monthly. If a family fails to pay the required amount the child is disenrolled from the program

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

___ Employer
_X_ Family
_X_ Absent parent
___ Private donations/sponsorship
___ Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

N/A

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

N/A

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

N/A

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income?

Because there are no cost-sharing requirements under SCHIP, aside from the nominal premium contributions for some families in Child Health Plus, it would not be possible for a family to exceed the 5 percent cap. Thus, insurers are not required to maintain systems that monitor cost-sharing by each family.

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

N/A

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

The State has not studied the possible effects of nominal premium contributions on participation in the program. The majority of the enrolled CHPlus population is fully subsidized and does not make a contribution toward the monthly premium. Since there is a minimal amount of cost sharing, through small premium contributions only, we conclude that these contributions are likely to have little, if any, impact on utilization since no payments are required at time of service.

3.4 How do you reach and inform potential enrollees?

The CHPlus program uses a variety of outreach and marketing approaches targeted at potential enrollees. The State Department of Health (Department) is responsible for the operation of all mass media campaigns. To date these campaigns have included television and radio spots, billboards, bus and subway posters, and the distribution of a variety of promotional materials. The Department also contracts with an independent organization to operate the "Growing Up Healthy" hotline, a toll free information service covering a wide range of health related areas. In addition to this hotline, program staff oversee a contract with the Health Plan

Association of New York (HPA) for outreach activities. One component of this contract is operation of a toll free hotline to provide specific program information to interested callers. Along with the toll free hotline service, the HPA maintains a presence at health fairs, conferences and community-based activities. Insurers who participate in the CHPlus program are required to perform outreach and marketing functions as specified in their contract. Marketing plans are reviewed on an ongoing basis to ensure the efforts are targeted at potential enrollees in the communities they service.

To further the State's efforts to reach and inform potential enrollees, a facilitated enrollment program is currently being developed. This program will assist families with the application process to enroll their children, if eligible, in CHPlus, Medicaid or WIC. A request for proposal was presented to local communities and community-based organizations to apply for funding to participate in this program. Approximately $10 million dollars over a 1 year period is allocated to fund the project. Awards have been given to 34 community-based organizations. This program requires that community-based organizations place trained facilitated enrollers in their local communities at times and in locations convenient for families. Facilitated enrollers will be trained in CHPlus and Medicaid eligibility requirements and will be authorized by the LDSS offices to conduct the face-to-face interview required for the Medicaid program. As stated earlier, this program will utilize the new "Growing Up Healthy" joint application. This facilitated enrollment program is truly innovative in its effort to remove the barriers to adequate health insurance coverage for all eligible children.

3.4.1 What client education and outreach approaches does your CHIP program use?

Recognizing that some enrollees may not have experience participating in a private, individual health insurance program, the enrollment process is designed to include an educational component. This education component orients the enrollee so that they can properly utilize benefits and services. Each enrollee is instructed on the procedures for selection of a primary care provider and on how to make appointments. Enrollees must be provided with information on covered benefits, proper use of the emergency room, and the provision of care outside of the insurer's service area. In the future, facilitated enrollers will also provide educational orientation to applicants.

Table 3.4.1 below indicates the client education and outreach approaches used in the CHPlus program and rates the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1

Approach	Medicaid CHIP Expansion		State-Designed CHIP Program "Child Health Plus"	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Billboards			**T**	4
Brochures/flyers			**T**	4

Table 3.4.1				
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program "Child Health Plus"	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Direct mail by State/enrollment broker/administrative contractor			**T**	3
Education sessions			**T**	3
Home visits by State/enrollment broker/administrative contractor				
Hotline			**T**	4
Incentives for education/outreach staff				
Incentives for enrollees				
Incentives for insurance agents				
Non-traditional hours for application intake			**T**	1
Prime-time TV advertisements			**T**	4
Public access cable TV			**T**	3
Public transportation ads			**T**	2
Radio/newspaper/TV advertisement and PSAs			**T**	4
Signs/posters			**T**	3
State/broker initiated phone calls				NA

3.4.2 Where does your CHIP program conduct client education and outreach?

Client education and outreach is conducted in a variety of settings. For example, the State toll-free hotline is advertised on all promotional materials. This hotline receives over two hundred phone calls per day from individuals inquiring about CHPlus. Promotional materials are distributed to community sites such as medical/dental offices, grocery stores, schools, health fairs, and laundry facilities. Other marketing efforts include advertisements in subways, at bus stops, on the back of milk cartons, grocery

receipts, cable television bill inserts, and restaurant place mats. Perhaps the most effective marketing effort is the television and radio advertisements that are run statewide.

While the State mandates that insurers are responsible for educating and orienting enrollees to the managed care model of health care, insurers are allowed flexibility on where these activities must occur. Insurers can provide them in their office, in the enrollees home or in another location convenient to both the plan and the enrollee.

Table 3.4.2 identifies all settings used for client education and outreach for CHPlus. Each setting used is also rated for effectiveness on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2

Setting	Medicaid CHIP Expansion		State-Designed CHIP Program "Child Health Plus"	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Battered women shelters				
Community sponsored events			**T**	2
Beneficiary's home			**T**	NA
Day care centers			**T**	1
Faith communities			**T**	1
Fast food restaurants			**T**	2
Grocery stores			**T**	1
Homeless shelters				
Job training centers				
Laundromats			**T**	1
Libraries				

Table 3.4.2				
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program "Child Health Plus"	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Local/community health centers			**T**	3
Point of service/provider locations			**T**	3
Public meetings/health fairs			**T**	2
Public housing			**T**	2

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

Data is collected by the organizations that maintain the toll free hotlines on how each caller to the hotline heard about the program. This enables program staff to estimate the effect of various types of advertising campaigns. The data collected by the hotline organizations indicates that callers first learn about CHPlus primarily through television and radio advertisements, from a friend, through Medicaid, a physician or school. Table 3.4.3 below shows the percentage of calls according to the top 5 referral sources. The source of referral is dependent on the volume of different media campaigns. Shortly after implementing an aggressive television media campaign in 1999, calls to the hotline increased significantly. When possible, advance notice is given to the hotline organizations of sizable media campaigns to be conducted. These organizations are then able to staff their phone lines to meet the increased demand

for information. The significant increase in program enrollment during the past 18 months indicates a high degree of effectiveness of these media campaigns.

TABLE 3.4.3	
How caller first heard about CHPlus	**Percentage of calls 1999**
Television / Radio	22.4 %
Friend / Relative	17.5 %
Medicaid / DSS	11.6 %
Doctor	9.4 %
School	8.8 %

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

The CHPlus and "Growing Up Healthy" hotlines are staffed by operators who are fluent in both English and Spanish. These operators also have access to the AT&T translation services for assistance with many other languages.

Because of the varied ethnic backgrounds of New York's population we are unable to print materials in all languages. The major promotional materials have been printed primarily in English and Spanish. Limited additional quantities of these same materials have also been produced in Chinese, Russian, Hebrew, Creole, Urdu, Hindi, and Korean. Insurers have also published materials in various languages relative to their target populations.

Under the facilitated enrollment program, we anticipate that promotional materials will be produced in the languages of the ethnic communities being targeted. In addition, facilitated enrollers will be fluent in the primary languages of the communities where they work.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

The toll-free hotline is perhaps the most effective method of educating interested persons about the CHPlus program. Descriptive statistics are recorded for each hotline call that is received. Data items such as gender, language of the caller, how the caller heard about the hotline, and the location of the caller are collected. The data show that television is the primary media from which most hotline callers first learn about CHPlus. Service/community organizations represent the next largest source of calls.

Targeting neighborhoods with language appropriate materials is also very effective. When the Health Plan Association (HPA) widely distributed a flyer in Chinese to neighborhoods in New York City, the caller response to the hotline was significant. The flyer advertised the hours of the Chinese speaking operator who then received a high volume of calls consistently during those hours.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

The CHPlus Program coordinates with a number of other health programs. For example, a joint application for the Medicaid, WIC and CHPlus programs has been developed and pilot tested. This application will allow easier coordination between the programs and make the application process easier for families by allowing them to complete one application for either CHPlus or Medicaid and WIC. Joint outreach has been done for CHPlus, Medicaid, WIC and the Prenatal Care Assistance Program (PCAP) through a brochure called "Growing Up Healthy". This brochure describes all four programs and the eligibility requirements under each.

Child Health Plus also coordinates with Maternal and Child Health Programs such as Early Intervention (EI), the Physically Handicapped Children's Program (PHCP) and School Health Programs. Under EI and PHCP, uninsured children are screened for eligibility in Medicaid or CHPlus and referrals are made to the appropriate program. CHPlus is the primary payer for services covered by either EI or PHCP and Child Health Plus. EI providers are encouraged to join the provider networks of CHPlus health plans. County Health Departments are also encouraged to become providers under the CHPlus program.

Under the School Health Program, uninsured children are referred to either CHPlus or Medicaid. Further coordination is planned by requiring CHPlus and Medicaid managed care health plans to contract with School Based Health Centers (SBHCs). Outreach has also been coordinated with the School Lunch Program.

Table 3.5 below identifies the areas of coordination between CHIP and other programs.

Table 3.5		
Type of coordination	Medicaid*	Maternal and child health
Administration		

Outreach	X	X
Eligibility determination	screening	screening
Service delivery	X	**X**
Procurement	X	
Contracting		
Data collection	X	
Quality assurance	X	

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

3.6 How do you avoid crowd-out of private insurance?

As a requirement of both state and federal law, applicants for CHPlus must not have equivalent insurance to be eligible to receive services. In addition, access to the State health benefits plan would disqualify a child from eligibility into CHPlus.

The CHPlus program is designed to prevent crowd-out. Only those children in families with a net income below 192% of federal poverty are eligible for subsidized insurance. Most persons at this income level do not have private health insurance. Therefore crowd-out has not shown to be a major problem. In addition, the CHPlus benefit package is designed to mirror commercial benefits so as not to create an incentive for individuals to drop private insurance coverage.

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

A monitoring process is ongoing and described in detail in the following section. As stated below, if crowd-out is found to be occurring there is a contingency plan to implement policies that will correct the problem.

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

To assess crowd-out, or the substitution of public insurance for private insurance, each applicant is required by State law to complete a questionnaire as part of the eligibility process. These specific questions on prior insurance status are designed to measure the extent crowd-out may be occurring. A complete questionnaire must accompany each application in order to determine eligibility. The questions pertaining to prior insurance status are mandated by the State and are as follows:

1. Number who answered "yes" to having health insurance in the past 6 months;
2. Of those with prior insurance, how many were insured through an employer;
3. Number who indicated the following reasons as to why the enrollee's prior employer based insurance was discontinued:

a. Employer discontinued offering the benefit or is no longer contributing towards premium for the enrollee but continued benefits for the working parent;
b. The premium was increased beyond what was affordable;
c. Child Health Plus is a less expensive insurance alternative;
d. Child Health Plus insurance benefits are better;
e. No longer working for the employer who offered the insurance.

The questionnaire results are compiled by insurers and reported to the State on a quarterly basis. The State then analyzes the data and determines a statewide "crowd out percentage". The State has established a policy that if, on average, over a 9 month period the crowd-out percentage equals or exceeds 8%, a waiting period may be imposed. If this policy is implemented, potential enrollees who voluntarily drop their employer-based health insurance to apply for CHPlus benefits will be required to wait 6 months before becoming eligible to receive services.

There are some instances that would exclude an applicant from the waiting period. These exclusions would be the following:

a. loss of employment due to factors other than voluntary separation;
b. death of the family member which results in termination of coverage under a group health plan under which the child is covered;
c. change to a new employer that does not provide an option for comprehensive health benefits coverage;
d. change of residence so that no employer-based comprehensive health benefits coverage is available;
e. discontinuation of comprehensive health benefits to all employees of the applicant's employer;
f. expiration of the coverage periods established by COBRA;

g. termination of comprehensive health benefits coverage due to a long-term disability.

Below is a table showing the results of the prior insurance status questionnaires for the period January 1, 1999 through September 30, 1999.

PRIOR INSURANCE STATUS	TOTAL
A. Number of new enrollees January 1, 1999 to September 30, 1999:	81,554
B. Number of enrollees who completed the prior insurance questions:	81,554
C. Number who answered 'No' to having health insurance, other than Child Health Plus, in the past 6 months	61,376
D. Number who answered 'Yes" to having health insurance in the past 6 months:	20,178
E. Of those with prior insurance, how many were insured through an employer:	9,825
F. Number who indicated the following reasons as to why the Enrollee's prior employer based insurance was discontinued:	
1. Employer discontinued offering this benefit or is no longer contributing towards premium for enrollee by continued benefit for working parent:	741
2. The premium was increased beyond what was affordable	1,580
3. Child Health Plus is a less expensive insurance alternative	1,569
4. Child Health Plus insurance benefits are better	1,658
5. No longer working for the employer who offered the insurance	4,277
CROWD-OUT % (1+3+4)/B	4.87%

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Table 4.1.1 CHIP Program Type **Child Health Plus**

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	282,741	519,401	4.4	7.3	55,759	202,281
Age						
Under 1	7,357	13,656	3.9	6.6	1,095	5,536
1-5	84,737	152,780	4.4	7.2	17,095	62,220
6-12	123,529	216,756	4.5	7.5	24,132	81,016
13-18	67,118	136,209	4.4	7.0	13,437	53,509
Countable Income Level*						
At or below 150% FPL	234,980	452,972	4.3	7.3	41,892	179,364

Table 4.1.1 CHIP Program Type **Child Health Plus**						
Above 150% FPL	47,761	66,429	5.1	7.2	13,867	22,917
Age and Income						
Under 1						
At or below 150% FPL	6,048	11,740	3.8	6.5	894	5,000
Above 150% FPL	1,309	1,916	4.3	7.3	301	536
1-5						
At or below 150% FPL	69,628	131,835	4.3	7.2	12,655	54,856
Above 150% FPL	15,109	20,945	5.1	7.3	4,440	7,364
6-12						
At or below 150% FPL	102,530	189,041	4.4	7.5	17,922	71,615
Above 150% FPL	20,999	27,715	5.2	7.4	6,210	9,401
13-18						
At or below 150% FPL	56,774	120,356	4.2	7.0	10,421	47,893
Above 150% FPL	10,344	15,853	4.9	7.0	3,016	5,616

Table 4.1.1 CHIP Program Type **Child Health Plus**						
Type of plan						
Fee-for-service	1,394	2,579	5.4	8.2	297	958
Managed care	281,347	516,822	4.4	5.3	55,462	201,323

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

Procedures for enrollment into CHPlus include a survey of all new applicants to assess prior insurance status. Each insurance plan under contract to provide CHPlus is required to report the results of these surveys on a quarterly basis. The table shown in section 3.6.2 of this report details these results for the period January 1, 1999 through September 30, 1999. This report shows that the majority of children applying for CHPlus benefits had no health insurance coverage during the 6 months prior to application. Of those who had employer based coverage at some time during the previous 6 months, nearly 60 percent indicated that loss of employment or benefits being unaffordable were the reasons for their insurance being discontinued.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

As described in Section 2.2.3 of this report, the New York State Small Business Health Insurance Partnership Program (NYSHIPP) and Voucher Insurance Program both provide affordable, quality health insurance coverage for individuals and

families. The NYSHIPP program has been very successful at assisting eligible employers and sole proprietors without employees in purchasing health insurance for their employees and dependents.

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

In FFY 1998, nearly 56,000 and in FFY 1999, approximately 200,000 children disenrolled from the CHPlus program. Quarterly reporting by each insurance plan details the reasons why families disenroll their children including lack of sufficient documentation during the presumptive eligibility period and failure to pay the family share of premium. Other reasons cover basic eligibility criteria such as the child is no longer eligible due to age, income, equivalent insurance coverage or residency. Because all enrollees are required to re-certify on an annual basis, some families fail to respond to requests for information from their insurer that will prove they remain eligible for the program. The incidence of this is expected to decrease when the facilitated enrollment process is implemented.

The disenrollment numbers displayed in Table 4.1.1 include all children who either voluntarily or involuntarily disenrolled from CHPlus. With changes to local economies and the employment status of families, many children move between public and private insurance coverage or from Child Health Plus to Medicaid.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

There are many reasons why a child may not re-enroll in CHPlus at the time of re-certification. These reasons include aging out of the program, a change in residency, or obtaining equivalent insurance. The quarterly data submissions required of all insurance plans detail these reasons that are specific to the time of re-certification. Data from these quarterly reports show that most of the children who do not re-enroll at the time of re-certification do so because the family either fails to produce the required documentation or the family voluntarily chooses not to re-enroll. During the last quarter of FFY '99, approximately 21,000 children did not re-enroll at the time of recertification. Of those 21,000, less than 3 percent did not re-enroll because they had obtained equivalent insurance. The majority of these 21,000 children did not recertify because of a lack of sufficient documentation or they voluntarily chose not to re-enroll.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

The data in the table below represents the total number of disenrollments for CHPlus enrollees during the last quarter of FFY '99. These numbers include those disenrolled at the time of recertification, after the presumptive eligibility period and at any other time during enrollment.

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total			65,646	
Access to commercial insurance			4,420 *	6.7%
Eligible for Medicaid				
Income too high			99	0.2%
Aged out of program			1,133	1.7%
Moved/died			669	1.0%
Nonpayment of premium			1,889	2.9%
Incomplete documentation			43,109	65.7%
Did not reply/unable to contact				
Other Family voluntarily chose not to re-enroll			7,420 **	11.3%

Table 4.2.3				
Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Other Family voluntarily chose to disenroll			1,520	2.3%
Other			5,387	8.2%

* NOTE: may include children who obtained equivalent insurance under Medicaid.
** NOTE: may include children of families who did not reply to recertification request.

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

Many insurers take steps to ensure that children who are eligible remain in the program. Phone calls to the home are made regularly to encourage families to comply with the eligibility requirements at the time of recertification. If a family fails to respond to recertification information requests, some insurers make home visits to ensure that the children continue to receive comprehensive health insurance coverage.

The facilitated enrollment initiative is likely to decrease dramatically the number of children who remain eligible for Child Health Plus but disenroll from the program, especially because of insufficient documentation . Enrollers will assist families in recertifying their children for programs prior to expiration of their 12-month enrollment period.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 $77,455,592

FFY 1999 $372,231,100

Table 4.3.1 CHIP Program Type **Child Health Plus**				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	$77,455,592	$372,231,100	$50,346,135	$241,950,215
Premiums for private health insurance (net of cost-sharing offsets)*	$75,962,517	$367,617,176	$49,375,635	$238,950,905

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap?

Expenditures applied to the 10 percent limit include outreach and marketing activities as described in Section 3 of this report, program administration and premiums for children who are presumptively enrolled but found to be ineligible at the end of the presumptive period.

What role did the 10 percent cap have in program design?

New York's Child Health Plus program was well established prior to Title XXI implementation. The 10 percent cap therefore did not have a role in program design but does require close monitoring for ongoing expenditures. Moreover, enrollment levels have reached a point where future efforts must be directed at the harder to reach populations. This in turn may result in a greater portion of expenditures devoted to outreach efforts. Therefore, the budgeting process in the future will require continual monitoring to ensure that the limits are not exceeded.

Table 4.3.2				
Type of expenditure	Medicaid CHIP Expansion Program		State-designed CHIP Program	
	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share				
Outreach			$973,605	$3,977,473
Administration			$519,470	636,451
Other Presumptive Eligibility			$6,756,506	$11,244,815
Federal share				
Outreach			$632,843	$2,585,358
Administration			$337,655	$413,694
Other Presumptive Eligibility			$4,391,729	$7,309,130

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

_X_ State appropriations
___ County/local funds
___ Employer contributions
___ Foundation grants
___ Private donations (such as United Way, sponsorship)

___ Other (specify) _____

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

All insurers under contract to the State to provide health insurance coverage to low-income children, through Child Health Plus or Medicaid, are monitored and evaluated closely to ensure that all enrollees have adequate access to care. These monitoring and evaluation procedures encompass monthly appointment audits and complaint reviews. In addition, each insurer is monitored periodically for network capacity, PCP/enrollee ratios and adherence to time/distance standards. Moreover, insurers utilization data, submitted every 6 months, is evaluated for appropriateness such as frequency of emergency room visitation, etc.

Table 4.4.1

Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program
Appointment audits	X	X
PCP/enrollee ratios	X	X
Time/distance standards	X	X
Urgent/routine care access standards		
Network capacity reviews (rural providers, safety net providers, specialty mix)	X	X
Complaint/grievance/ disenrollment reviews	X	X
Case file reviews		

Beneficiary surveys		
Utilization analysis (emergency room use, preventive care use)	X	X

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

All insurers under contract to New York State to provide Child Health Plus or Medicaid managed care benefits are required to submit utilization data to the Department every 6 months. These semi-annual reports detail visits and procedures in areas of allowable benefits such as inpatient hospitalizations, ambulatory care visits by type of service, ancillary visits and procedures by type of service and emergency room usage. In addition to these semi-annual reports, all managed care organizations certified by the Department of Health prior to 1998, are required to submit a series of measures designed to examine managed care plan performance in several key areas. These measures comprise New York State's Quality Assurance Reporting Requirements (QARR) and are largely adopted from the National Committee for Quality Assurance's HEDIS®. The QARR assess quality, access, utilization and effectiveness of care.

Table 4.4.2

Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program
Requiring submission of raw encounter data by health plans	_X_ Yes ___ No	___ Yes _X__ No
Requiring submission of aggregate HEDIS data by health plans	_X_ Yes ___ No	_X_ Yes ___ No
Other (specify) QARR	_X_ Yes ___ No	_X_ Yes ___ No

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

CHPlus program staff monitor access to care on an ongoing basis. Each insurer is required to submit their provider networks for review. Each network is evaluated for time/distance standards as well as specialty composition. State-of-the-art mapping techniques are used to apply these time and distance standards to ensure adequate access for all enrollees. In addition, QARR uses the percentage of individuals who received preventive or ambulatory services as an indicator of access. The 1998 QARR results for access indicate that well over 80 percent of enrolled children in CHPlus received preventive or ambulatory services.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

QARR measures were first collected for CHPlus in 1998. These measures will continue to be collected and for subsequent years provide trend analysis. The trend analysis will improve the quality of care provided to enrollees by publicizing individual health plan characteristics thereby increasing accountability to the public.

4.5 How are you measuring the quality of care received by CHIP enrollees?

As described in section 4.4.2, the QARR measures are comprised of a series of measures designed to examine managed care plan management and performance in several key areas. The measures are largely adopted from the National Commission for Quality Assurance's (NCQA) HEDIS® reporting requirements with several New York State specific measures added to address public health issues of particular significance in New York, such as lead testing of children.

Twenty-four plans were under contract to the Department to provide Child Health Plus in 1998. All 24 plans were required to report data on a select set of measures (9) applicable to this unique population.

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

The QARR measures collected from each insurer specific to CHPlus provide useful information relative to well-child care and childhood immunizations.
The following measures are collected:

- Lead screening
- Immunizations –
  - Diphtheria – tetanus – pertussis
  - Inactive polio virus vaccine
  - Oral polio virus vaccine
  - Measles – mumps – rubella
  - Hemophilus influenza type B
  - Hepatitis B vaccine
- Well-child visits; all ages
- Alcohol, substance and tobacco use screening
- Appropriate use of medications for children with asthma

In addition to the QARR measures, all insurers are monitored by the approaches listed in Table 4.5.1.

Table 4.5.1

Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program
Focused studies (specify)	MCO	
Client satisfaction surveys	MCO	MCO
Complaint/grievance/ Disenrollment reviews	MCO	MCO
Sentinel event reviews		
Plan site visits	MCO	
Case file reviews		

Independent peer review	MCO	
HEDIS performance measurement	MCO	MCO
Other performance measurement (specify) QARR	MCO	MCO

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

The New York State Department of Health's Office of Managed Care, recently released ***The 1998 Quality Assurance Reporting Requirements, A Report on Managed Care Performance.*** This report, attached as Appendix C, is the New York State Department of Health's annual publication of quality, access, utilization and descriptive data collected from managed care plans licensed to operate in New York State. As stated above, the Child Health Plus Program in New York State participates with the Office of Managed Care in identifying appropriate HEDIS® and QARR measures to examine managed care plan management and performance as it pertains to CHIP enrollees. The measures are broken down into four major categories: effectiveness of care; access and availability of care; uses of services; and health plan descriptive information. For the 1998-reporting year, the plans participating in the Child Health Plus Program reported on nine measures. These measures were: Adolescent Immunizations; Alcohol Substance Abuse and Tobacco Screening and Counseling for ages 12-21; Childhood Immunizations; Lead Screening for Children age 2; Use of Medications for People with Asthma (Ages 5-20 years); Children's Access to Primary Care Providers; Adolescent Well Child Visits 12-21; Frequency of Selected Procedures, Myringotomy and Tonsillectomy; Well Child Visits (15 months); Well Child Visits (3,4,5,6 years).

Attached is a table depicting the rates for all QARR measures for the 1998 reporting year by Commercial, Medicaid and Child Health Plus enrollees. For the most part, the Child Health Plus rates are comparable to the commercial and Medicaid populations. The rates for two of the nine measures are expectedly lower than the Medicaid and commercial population due to small sample sizes and other factors. These two measures, Adolescent Immunization Status and the Use of Appropriate Medications for People with Asthma are described below.

The Adolescent Immunization Status is a new QARR measure for 1998 and was collected for Child Health Plus Program enrollees only. The rates for this new measure were expectedly low for a number of reasons. Due to the unfamiliar, and often increased complexity of the new specifications, clarifications are often needed while plans are

developing their rates. Plans need to become familiar with the reporting requirements and the parameters of new measures. Historically, first year reporting usually yields lower rates than subsequent years.

Secondly, the measure itself has difficult parameters for plans whose enrollees are new to the plan. It is recommended that children be fully immunized by age two. However, a second dose of measles vaccine, usually administered as measles-mumps-rubella (MMR), is required between four and six years of age. Because the Childhood Immunization measure evaluates the immunization status of children age two, the second MMR cannot be included in the Childhood Immunization measure. Instead, MMR given between four and six years of age is included in the evaluation of the immunization status of adolescents. This measure shows the percentage of adolescents who received the appropriate immunizations for measles, mumps and rubella which includes the second dose of the two-dose series. In reality, this means that the medical record for a Child Health Plus enrollee must contain immunization history greater than 5 years old in order to meet the requirements of the measure. The difficulty of plans obtaining complete immunization history is probably the largest contributing factor accounting for the low rates of adolescent immunization status measure.

The Use of Appropriate Medications for People with Asthma is one measure where the Child Health Plus Program rates were lower than both the Medicaid and Commercial populations. The Child Health Plus statewide rate was 48% compared to the commercial rate of 53% and Medicaid rate of 65%. The lower rate for Child Health Plus Program is attributed to the small sample sizes in all but one plan. The criteria for excluding data is:

- The denominator is less than 30, resulting in an unreliable rate.
- The data for the particular measure could not be substantiated by audit.
- No enrollee could meet the eligibility requirements (such as continuous enrollment).

Small sample size was an issue in a number of measures collected for 1998. It is anticipated that as the program grows and plans can meet the continuous enrollment criteria established for most measures and sample sizes increase, performance in this and other measures will improve.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

The Child Health Plus Program will continue to require plans to report annually on selected measures applicable to the Child Health Plus Program population. As future years data become available, the Program will be able to perform trend

analysis on plan performance. At that time the CHIP measures will also be compared to national benchmarks such as Health People 2000 goals and NCQA's Quality Compass rates.

For 1999, 5 additional measures will be collected. These measures include Annual Dental Visits; Practitioner Turnover; Inpatient Utilization; Ambulatory Care and Enrollment by County. One measure for the 1999-reporting year has been discontinued. New York Public Health Law now requires children have a second MMR and third hepatitis B prior to entering school. Children will have received the entire series of immunizations prior to age 13. Therefore, Adolescent Immunizations, which was specific to age 13, will not be included in the 1999 QARR. The data for 1999 are to be submitted to the Office of Managed Care by July 15, 2000. Review and analysis of the data will begin in the last quarter of 2000.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

First time enrollment into CHPlus is a simple and user-friendly process. All insurers accept applications for enrollment through the mail. If an applicant appears eligible but is missing certain qualifying documents the child is enrolled presumptively for a period of 60 days. A similar process is necessary for enrollees to continue receiving services after their initial 12 month period of enrollment. Each applicant is notified 60 days prior to their recertification date of the need to reapply for enrollment. Despite the easy re-application process there appear to be a considerable number of enrollees who fail to recertify due to a lack of sufficient documentation.

To make enrollment friendlier to families and as a means of ensuring that children enroll in the insurance program they are eligible for, the facilitated enrollment initiative was developed. Facilitated enrollment was designed to be a user-friendly method of applying for one of three programs, Child Health Plus, Medicaid or the Special Supplemental Food Program for Women, Infants and Children (WIC). Under this initiative, culturally sensitive and linguistically competent enrollers will be located in community settings during non-traditional hours such as evenings and weekends. They will assist families in

completing the Growing up Healthy application, a joint application for the three programs. The enroller will conduct a screen to determine which program the child appears eligible for and will help the family collect the documentation required for that program. If the child appears Medicaid eligible, the enroller will be able to complete the face-to-face interview required for Medicaid so the family will not need to go to the LDSS services office to apply. The enroller will also be able to educate the family about managed care and will be able to assist in the plan selection process.

Another area the program will be improving on is the recertification rate. Currently, a significant number of families fail to recertify their children at the end of their 12-month period of enrollment. Facilitated enrollment should help increase the number of children who successfully recertify for Child Health Plus. In addition to enrolling new children, facilitated enrollers will assist families in completing the recertification process. Enrollers will follow-up with families to ensure the recertification process is completed in a timely manner preventing a lapse in coverage.

5.1.2 Outreach

The New York State Child Health Plus program has been in existence since 1991. Therefore, the program has a longstanding history of outreach and marketing experience. These activities were significantly enhanced with the availability of Title XXI money effective April 15, 1998.

To date, the New York State Child Health Plus program has used a three-prong approach for outreach and marketing efforts. The rapid expansion in Child Health Plus enrollment is a direct result of these activities. Enrollment has increased from approximately 120,000 children to 390,000 children in roughly 18 months. Specific outreach and marketing activities that can be identified as successful are as follows:

- The development of an easily recognizable Child Health Plus logo that is used in all promotional materials. This logo provides quick visual recognition for the program.
- The establishment of a toll free hotline that gives perspective families instant access to more detailed information at no cost. New York State currently has 2 hot line numbers available for the public.
- The use of a broad range of communication mediums that are designed to reach the target audience including:
  - TV and radio spots
  - Billboards
  - Bus and bus stop posters
  - Posters
  - Literature including booklets and flyers, produced in English, Spanish and Chinese. Testing has been done using Urdo, Creole, Russian, Hebrew, and others.

- Promotional materials, including: coloring books, Frisbees, sweatshirts/tee shirts, magnets, pens, pencils, crayons, post-it notes, note pads, first aid cards for choking infants, tooth brushes, pins, mugs, etc.

- The use of an outside contractor (the Health Plan Association of New York) who has provided the program with a Statewide presence. The contract gives the program the ability to immediately respond to requests for information and readily provide speakers, conduct presentations and demonstrations, and staff information booths on short notice.
- The formation of a large number of partnerships that have successfully worked in a collaborative effort to reach the targeted populations. The partnerships have included representatives from the following sectors:
  - Advocacy groups (Children's Defense Fund, Statewide Youth Advocacy Group, Planned Parenthood, etc.)
  - Business groups (K-mart, Walmart, Better Business Bureaus, etc.)
  - Religious groups
  - Public service organizations
  - Government agencies (State Education Department, Temporary and Disability Assistance, Unemployment Insurance, State Insurance Department, Office of Mental Health, etc.)
  - Community-based organizations
  - Schools and school-based entities
  - Healthcare providers (various physician professional associations, Health Care Association of New York State, Health and Hospitals Corporation, etc.)
  - The judicial system
  - The legal system; and
  - Charitable organizations (Catholic Charities, United Way, etc.)

While the program's media campaign has been well received and highly effective, it has been felt that more attention should be given to minority populations. The program recognizes the need for increased cultural sensitivity and is pursuing strategies that will address these community concerns.

As the program has gained more experience in outreach and marketing activities, it has become increasingly apparent that there are large pockets of unserved and hard-to-reach communities that do not have access or exposure to the more traditional strategies described above. These populations may constitute religious groups whose religious rules of conduct prohibit exposure to the lay press, isolated ethnic communities as well as individuals that are deficient in languages other than those they learn as part of their cultural group. These subgroups and isolated communities pose a special challenge to the program. Facilitated enrollment will help address this challenge. Additional strategies designed to break through these cultural and religious barriers are currently under review.

Another special challenge to the program is the difficulty some families have in negotiating the enrollment process including completion of the application and submission of the required supporting documentation. Recognizing the difficulty these families have and the subsequent loss of these families to the system, the program has devised a concept of facilitated enrollment. Under this facilitated enrollment model, facilitated enrollers will be thoroughly trained to assist families with the application and they will serve as the intermediaries between the family and the program as the application proceeds through the review and approval process. The concept of facilitated enrollment requires that facilitated enrollers be stationed in their local communities at times and in locations convenient to residents. Thus, it is hoped that the program will be able to eliminate or reduce the known barriers that continue to stand in the way of the enrollment of these isolated and hard-to-reach groups.

Participants in this project were selected through a Request for Proposal process that was released earlier in the year. Thirty-four awards were subsequently issued to community-based organizations. The contracts for the facilitated enrollers are currently being finalized. Training for the facilitated enrollers is to begin in the early part of 2000.

Training for the facilitated enrollers is being done by an independent organization selected under a second Request for Proposal. It is envisioned that the successful implementation of the facilitated enrollment model will be instrumental in ensuring that Child Health Plus be more culturally sensitive to the communities it is designed to serve.

In terms of evaluation of the outreach and marketing efforts, the outreach and marketing contractor and the hot line contractors file monthly reports with the program's staff. Such reports track telephone calls by a variety of categories and report on the success or failure of various outreach and marketing activities.

Given the tremendous increase in enrollment in a relatively short time, it is anticipated that New York state will continue all of the described outreach and marketing activities implemented to date. Moreover, the facilitated enrollment effort will focus even more energy on successfully reaching the uninsured in the State.

5.1.3 Benefit Structure

When Child Health Plus was first introduced in 1991, the benefits were outpatient-only services for children under 13 years of age. In 1997, the program became available to children up to 19 years of age and the benefit package was expanded to include inpatient health services. This expansion improved continuity of care so children who require hospitalization could continue to have their care overseen by their primary care physician. With the approval of the Title XXI State Plan, the benefit package further expanded. As of February 1, 1999, benefits now include inpatient mental health services, vision care and dental care, three areas determined to be of need.

The Child Health Plus dental benefit was implemented in February 1999. The services covered under this benefit mirror the services provided to individuals under the age 19 by Medicaid, with the exception of orthodontics. This benefit is administered by the individual health plans as are all child health plan benefits. The negotiated rates between the plans and individual dentists were submitted to the State Insurance Department for approval and represented an actuarially based estimate of cost, which was added to the existing premium. The plans were required to provide access to a dentist within 30 miles or 30 minutes of a child's home where possible. The dental networks were slow to develop as this was a new insurance product for many of the plans and they had little experience with pricing and predicting to what extent the individual services would be utilized. Initially, a few plans thought that they could pay low fees to dentists by offering them a high volume but this was not true as most dentists already had full practices and the increased volume was no incentive. The plans have also had difficulty finding dentists, especially in rural areas of the state.

The Department has worked extensively with the individual plans to assess the adequacy of their networks. Plans have increased their networks considerably, although there are still areas in northern and central New York where there are very few dentists, most of which have full practices and are not interested in becoming part of the network. In these areas, a plan has allowed a child to go "out of network" if there is no network dentist within the 30 mile/30 minute required radius.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

The required family contribution amounts have changed during the life of the Child Health Plus program. Initially the family contribution toward the premium for families with household incomes at or above 160% of the Federal Poverty Level was a flat amount of $25 per child per year ($100 family maximum). This amount was changed to an amount that is paid monthly and varies by household income level. The current method recognizes various income levels through incremental increases in family contributions. The current family contribution level is as follows:

160%-222% gross FPL = $9/per child/per month- ($27/month maximum/family)
223%-230% gross FPL = $15/per child/per month- ($45/month maximum/family)

The current contribution levels are such that they would not result in any family contribution exceeding the 5% of income cap.

There currently are no co-payment or deductible requirements for services used by enrollees. Previously, families were required to pay a small co-payment for prescription drugs ($1.00 to $3.00); a $2.00 co-payment for physician office visits (excluding wellcare visits) and a co-pay for inappropriate use of the Emergency Room. The elimination of all co-payments removes the financial barriers to access to care for children enrolled. This also ensures the program is in compliance with the requirement that family contributions not exceed 5% of a family's income.

5.1.5 Delivery System

Child Health Plus is a managed care product delivered through 32 insurers statewide. One or more insurers service all areas of the state. Each insurer is responsible for their provider network and ensuring that it is sufficient for their number of enrollees. Provider network information is submitted to the Department and the review is coordinated with the Office of Managed Care. Currently, a plan requesting to expand their service area must receive approval from the Office of Managed Care in that particular county before being approved for Child Health Plus. A coordinated provider network for Medicaid Managed Care and Child Health Plus provide children who move between programs seamless coverage so they will not have to change providers. This effort has been successful in most areas of the state although a few insurers have experienced

problems in securing managed care arrangements with providers.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

As required under federal law, any child who is insured at the time of application will be denied eligibility. Because of this requirement some believe that crowd-out could occur. The Child Health Plus program monitors its occurrence through requiring that specific questions be answered on all applications. If these questions are not answered, the application is considered incomplete and will not be processed until responses are given. Section 3 of this report lists the questions pertaining to prior insurance status that are mandated by the State.

Insurers collect this information and report it to the State on a quarterly basis. The State then conducts analysis and determines the "crowd out percentage". If, on a 9-month average, the crowd-out percentage equals or exceeds 8%, a 6-month wait period may be instituted. If such a wait period is instituted, a potential enrollee who voluntarily drops employer-based health insurance and applies for Child Health Plus, will have to wait 6 months before being eligible for Child Health Plus. The wait period would not be applicable in the following circumstances:

a. loss of employment due to factors other than voluntary separation;
b. death of the family member which results in termination of coverage under a group health plan under which the child is covered;
c. change to a new employer that does not provide an option for comprehensive health benefits coverage;
d. change of residence so that no employer-based comprehensive health benefits coverage is available;
e. discontinuation of comprehensive health benefits to all employees of the applicant's employer;
f. expiration of the coverage periods established by COBRA;

g. termination of comprehensive health benefits coverage due to long-term disability.

All insurers must submit their annual marketing plans and any marketing materials to Child Health Plus staff for review and approval. The review and approval process includes review for any indication that the plan is, or has intentions of, marketing to businesses. Furthermore, the Child Health Plus program director has issued clarification correspondence, which reiterates that Child Health Plus is not a substitute for employer-based insurance.

The NYS Department of Health has developed a joint application which is currently being used in pilot demonstrations and which will be implemented on a statewide basis in the near future. The joint application is a coordinated effort between Medicaid, Child Health Plus and the WIC program and will be used by the insurers as well as the facilitated enrollers. One of the major goals of the joint application is to ensure that enrollees are enrolled in the appropriate program from the onset.

As discussed in Section 5.1.2, Outreach, the Department has formed a number of partnerships with other organizations and other state agencies. These partnerships, listed in Section 5.1.2, provide a coordinated effort between public and private programs.

5.1.7 Evaluation and Monitoring (including data reporting)

All current evaluation and monitoring activities will be continued for Child Health Plus. All procedures will be continued for enrollment, expenditure and utilization data reporting. In addition, the organizations selected to perform facilitated enrollment will be closely monitored to ensure that eligible children are enrolled in the appropriate program. Each organization will also be monitored for its efforts in enrolling those hard-to-reach populations, particularly minority and culturally separate groups.

All insurers are audited annually for compliance with program requirements. These audits include on site reviews of enrollee files for eligibility determination practices as well as access to care issues. Each insurer is subject to specific

standards which if not met result in financial penalties. If an insurer is found to be out of compliance, they must submit a plan of correction to the Department. To date only a few insurers have been subject to a second stage audit whereby an insurer is evaluated for compliance with its submitted plan of correction.

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

New York State plans on improving the availability of health insurance and health care by implementation of the facilitated enrollment initiative. Facilitated enrollment is a convenient, user-friendly method of applying for the Child Health Plus, Medicaid and WIC programs. Enrollers will be available in community-settings frequented by the target population. For the convenience of families, they will be available during non-traditional hours, including evenings and weekends. Some enrollers will also perform home visits to families. Enrollers will be culturally sensitive and proficient in the languages of the communities they service. They will assist families in completing the Growing up Healthy joint application and in collecting required documentation. To help ensure that children enroll in the appropriate program, enrollers will screen families to determine which program the child is eligible for, Medicaid or Child Health Plus. If the child appears Medicaid eligible, the enroller will complete the face-to-face interview required for Medicaid so the family does not need to go the LDSS office to apply. The enroller will also assist the family in selecting a managed care plan. Once the application is complete and documentation requirements are satisfied, applications will be sent to either the health plan or the LDSS who will determine eligibility.

Making the application process more convenient and user-friendly, coupled with having culturally appropriate enrollers, will increase enrollment of the hard-to-reach and vulnerable populations. In addition, the facilitated enrollment process will help ensure that children enroll in the program they are eligible for.

Thirty-four organizations, each with multiple subcontractors, were selected to perform facilitated enrollment. An organization was also selected to train the facilitated enrollment organizations. This process is currently underway. Facilitated enrollment should be operational on a statewide basis in the very near future.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

The enactment of Title XXI provided New York State with additional funding in support for it's long standing Child Health Plus program. Since 1992 this program has provided thousands of low-income children with needed health insurance coverage. Although New York's benefit package was "grandfathered in" under Title XXI requirements, the statute placed certain constraints on a program already well established. We believe that the intent of Title XXI was to provide states needed flexibility to design their own programs to best meet the needs of their state. Much of what has been proposed in the pending regulations limits this needed flexibility and appears to be patterned after Medicaid. These proposed regulations would require states to build infrastructures similar to that required of Medicaid, thereby creating an administrative cost burden that goes beyond the ten-percent maximum.

New York State recommends that the original intent of the program be preserved by allowing states flexibility to administer their programs in the most cost effective and efficient manner they deem appropriate. New York State makes the following recommendations:

1. To allow states the flexibility to change funding sources if the need arises. The proposed regulations require an amendment if the source of the State share of funding changes. The funding source should be the responsibility of the State and should be left to the State to operate in a manner consistent with that responsibility as long as no violation of Federal provisions exist.
2. To allow states flexibility in defining "creditable coverage". Many children in New York State have catastrophic coverage policies which are limited to types of services not frequently used by children. These type policies do not cover many of the services intended by Title XXI such as well-child visits and immunizations. The current interpretation of Title XXI precludes children with these limited health coverage policies from enrolling in SCHIP.
3. To redefine those expenditures which are subject to the 10 percent cap. Under current statute any expenditure which is not specifically defined as premiums is included in the calculation of the 10 percent cap. Costs such as premiums for presumptively enrolled children ultimately found ineligible for the program and fee-for-service expenditures are included in this limit. However premiums for any other child are not included. By including these types of expenditures in the calculation of the 10 percent limit, our outreach, marketing and administrative expenditures become limited. We believe that all expenditures for any type of premium or health care service should be excluded from the 10 percent limit.
4. To increase the allotments to states up to the amount necessary for states to receive an enhanced match rate on their total expenditures for SCHIP. New York estimates that they will have spent more than the total of their first three years allotment by the end of FFY 2000. This three year time period is important since states are allowed three years in which to spend their first year's allotment. In order for New York to continue its successful Child Health Plus program additional federal support will be necessary. According to recent projections less than half of the states currently participating in Title XXI will have spent their first years allotment by the end of FFY 2000. Therefore we recommend that those states that exceed their approved allotments be given the necessary funding to sustain their successful programs. Additionally, the legislatively authorized changes to the allotment formula will hurt those states who have rapidly enrolled children in their programs and thus will not have sufficient funding to maintain existing enrollment.

APPENDIX A

CHILD HEALTH PLUS BENEFITS PACKAGE

(No Pre-Existing Condition Limitations Permitted)

General Coverage	Scope of Coverage	Level of Coverage
Pediatric Health Promotion Visits	Well child care visits in accordance with visitation schedule established by American Academy of Pediatrics, and the New York State Department of Health recommended immunization schedule.	Includes all services related to visits. Includes immunizations, well child care, health education, tuberculin testing (mantoux), hearing testing, dental and developmental screening, clinical laboratory and radiological tests, eye screening, and lead screening.

General Coverage	Scope of Coverage	Level of Coverage
Inpatient Hospital Medical or Surgical Care	As a registered bed patient for treatment of an illness, injury or condition which cannot be treated on an outpatient basis. The hospital must be a short-term, acute care facility and New York State licensed.	No benefits will be provided for any out-of-hospital days, or if inpatient care was not necessary; no benefits are provided after discharge; benefits are paid in full for accommodations in a semi-private room. Includes 365 days per year coverage for inpatient hospital services and services provided by physicians and other professional personnel for covered inpatient services: bed and board, including special diet and nutritional therapy: general, special and critical care nursing services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care; oxygen and other inhalation therapeutic services and supplies; drugs and medications that are not experimental; sera, biologicals, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies; blood products, except when participation in a volunteer blood replacement program is available to the insured or covered person, and services and equipment related to their administration; facilities, services, supplies and equipment related to physical medicine and occupational therapy and rehabilitation; facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electro-encephalographic studies and examinations; facilities, services, supplies and equipment related to radiation and nuclear therapy; facilities, services, supplies and equipment related to emergency medical care; chemotherapy; any additional medical, surgical, or related services, supplies and

General Coverage	Scope of Coverage	Level of Coverage
Inpatient Mental Health and Alcohol and Substance Abuse Services	Services to be provided in a facility operated by OMH under Sec. 7.17 of the Mental Hygiene Law, or a facility issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law or a general hospital as defined in Article 28 of the Public Health Law.	A combined 30 days per calendar year for inpatient mental health services, inpatient detoxification and inpatient rehabilitation.
Professional Services for Diagnosis and Treatment of Illness and Injury	Provides services on ambulatory basis by a covered provider for medically necessary diagnosis and treatment of sickness and injury and other conditions. Includes all services related to visits. Professional services are provided on outpatient basis and inpatient basis.	No limitations. Includes wound dressing and casts to immobilize fractures for the immediate treatment of the medical condition. Injections and medications provided at the time of the office visit or therapy will be covered. Includes audiometric testing where deemed medically necessary.

General Coverage	Scope of Coverage	Level of Coverage
Outpatient Surgery	Procedure performed within the provider's office will be covered as well as "ambulatory surgery procedures" which may be performed in a hospital-based ambulatory surgery service or a freestanding ambulatory surgery center.	The utilization review process must ensure that the ambulatory surgery is appropriately provided.
Diagnostic and Laboratory Tests	Prescribed ambulatory clinical laboratory tests and diagnostic x-rays.	No limitations.

General Coverage	Scope of Coverage	Level of Coverage
Durable Medical Equipment, Prosthetic Appliances and Orthotic Devices	Durable Medical Equipment means devices and equipment ordered by a practitioner for the treatment of a specific medical condition which a) can withstand repeated use for a protracted period of time; b) are primarily and customarily used for medical purposes; c) are generally not useful in the absence of illness or injury; and d) are usually not fitted, designed or fashioned for a particular person's use. DME intended for use by one person may be custom-made or customized. Prosthetic Appliances are those appliances and devices ordered by a qualified practitioner which replace any missing part of the body. Orthotic Devices are those devices which are used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.	Includes hospital beds and accessories, oxygen and oxygen supplies, pressure pads, volume ventilators, therapeutic ventilators, nebulizers and other equipment for respiratory care, traction equipment, walkers, wheelchairs and accessories, commode chairs, toilet rails, apnea monitors, patient lifts, nutrition infusion pumps, ambulatory infusion pumps and other miscellaneous DME. DME coverage includes equipment servicing (labor and parts). Covered without limitation except that there is no coverage for cranial prostheses (i.e. wigs) and dental prostheses, except those made necessary due to accidental injury to sound, natural teeth and provided within twelve months of the accident, and except for dental prostheses needed in treatment of a congenital abnormality or as part of reconstructive surgery. No limitations on orthotic devices except that devices prescribed solely for use during sports are not covered.

General Coverage	Scope of Coverage	Level of Coverage
Therapeutic Services.	Ambulatory radiation therapy, chemotherapy, injections and medications provided at time of therapy (i.e. chemotherapy) will also be covered. Hemodialysis	No limitations. These therapies must be medically necessary and under the supervision of referral of a licensed physician. Short term physical and occupational therapies will be covered when ordered by a physician. No procedure or services considered experimental will be reimbursed. Determination of the need for services and whether home based or facility based treatment is appropriate.
Speech and Hearing Services including hearing aids.	Hearing examinations to determine the need for corrective action and speech therapy performed by an audiologist, language pathologist, a speech therapist and/or otolaryngologist.	One hearing examination per calendar year is covered. Hearing aids, including batteries and repairs, are covered. Covered speech therapy services are those required for a condition amenable to significant clinical improvement within a two month period, beginning with the first day of therapy.
Pre-surgical Testing.	All tests (laboratory, x-ray, etc.) necessary prior to inpatient or outpatient surgery.	Benefits are available if a physician orders the tests: proper diagnosis and treatment require the tests; and the surgery takes place within seven days after the testing. If surgery is canceled because of pre-surgical test findings or as a result of a Second Opinion on Surgery, the cost of the tests will be covered.
Second Surgical Opinion	Provided by a qualified physician.	No limitations.
Second Medical Opinion.	Provided by an appropriate specialist, including one affiliated with a specialty care center.	A second medical opinion is available in the event of a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation of a course of treatment of cancer.
Outpatient visits for mental health and for the diagnosis and treatment of alcoholism and substance abuse.	Services must be provided by certified and/or licensed professionals.	A combined 60 outpatient visits per calendar year. Visits may be for family therapy related to the alcohol or substance abuse.

General Coverage	Scope of Coverage	Level of Coverage
Home Health Care Services	The care and treatment of a covered person who is under the care of a physician but only if hospitalization or confinement in a skilled nursing facility would otherwise have been required if home care was not provided and the plan covering the home health service is established and provided in writing by such physician.	Home care shall be provided by a certified home health agency possessing a valid certificate of approval issued pursuant to article thirty-six of the public health law. Home care shall consist of one or more of the following: part-time or intermittent home health aide services which consist primarily of caring for the patient, physical, occupational, or speech therapy if provided by the home health agency and medical supplies, drugs and medications prescribed by a physician, and laboratory services by or on behalf of a certified home health agency to the extent such items would have been covered or provided under the contract if the covered person had been hospitalized or confined in a skilled nursing facility. The contact must provide forty such visits in any calendar year, if such visits are medically necessary.
Prescription and Non-prescription Drugs.	Prescription and non-prescription medications must be authorized by a professional licensed to write prescriptions.	Prescriptions must be medically necessary. May be limited to generic medications where medically acceptable. Includes family planning or contraceptive medications or devices. All medications used for preventive and therapeutic purposes will be covered. Vitamins are not covered except when necessary to treat a diagnosed illness or condition. Coverage includes enteral formulas for home use for which a physician or other provider authorized to prescribe has issued a written order. Enteral formulas for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein. Coverage for such modified solid food products shall not exceed $2500 per calendar year.

General Coverage	Scope of Coverage	Level of Coverage
Emergency Medical Services	For services to treat an emergency condition in hospital facilities. For the purpose of this provision, "emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in : (A) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (B) serious impairment to such person's bodily functions; (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.	No limitations.

General Coverage	Scope of Coverage	Level of Coverage
Maternity Care	Inpatient hospital coverage for at least 48 hours after childbirth for any delivery other than a C-Section and in at least 96 hours following a C-Section. Also coverage of parent education, assistance and training in breast and bottle feeding and any necessary maternal and newborn clinical assessments. The mother shall have the option to be discharged earlier than the 48/96 hours, provided that at least one home care visit is covered post-discharge. Prenatal, labor and delivery care is covered.	No limitations; (however subsidized children requiring maternity care services will be referred to Medicaid).
Diabetic Supplies and Equipment.	Coverage includes insulin, blood glucose monitors, blood glucose monitors for legally blind, data management systems, test strips for monitors and visual reading, urine test strips, insulin, injection aids, cartridges for legally blind, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, oral agents.	As prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law.

General Coverage	Scope of Coverage	Level of Coverage
Diabetic Education and Home Visits.	Diabetes self-management education (including diet); reeducation or refresher. Home visits for diabetic monitoring and/or education.	Limited to visits medically necessary where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management or where reeducation is necessary. May be provided by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified diagnosis nutritionist, certified dietician or registered dietician upon the referral of a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law and may be limited to group settings wherever practicable.

General Coverage	Scope of Coverage	Level of Coverage
Emergency, Preventive and Routine Vision Care.	Vision examinations performed by a physician, or optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription.	The vision examination may include, but is not limited to: - case history - external examination of the eye and external or internal - examination of the eye - ophthalmoscopic exam - determination of refractive status - binocular balance - tonometry tests for glaucoma - gross visual fields and color vision testing - summary findings and recommendations for corrective lenses
	Prescribed Lenses	At a minimum, quality standard prescription lenses provided by a physician, optometrist or optician are to be covered once in any twelve month period, unless required more frequently with appropriate documentation. The lenses may be glass or plastic lenses.
	Frames	At a minimum, standard frames adequate to hold lenses will be covered once in any twelve month period, unless required more frequently with appropriate documentation.
	Contact Lenses	Covered when medically necessary

General Coverage	Scope of Coverage	Level of Coverage
Emergency, Preventive and Routine Dental Care.	Emergency Dental Care	Includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.
	Preventive Dental Care	Includes procedures which help prevent oral disease from occurring, including but limited to: - prophylaxis: scaling and polishing the teeth at 6 month intervals. - Topical fluoride application at 6 month intervals where local water supply is not fluoridated. - Sealants on unrestored permanent molar teeth.
	Routine Dental Care	- dental examinations, visits and consultations covered once within 6 consecutive period (when primary teeth erupt). - x-ray, full mouth x-rays at 36 month intervals, if necessary, bitewing x-rays at 6-12 month intervals, or panoramic x-rays at 36 month intervals if necessary; and other x-rays as required (once primary teeth erupt). - All necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization including: - preoperative care - postoperative care - In office conscious sedation - Amalgam, composite restorations and stainless steel crowns - Other restorative materials appropriate for children
	Endodontics	Includes all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.
	Prosthodontics	Removable: complete or partial dentures including six months follow-up care. Additional services include insertion of identification slips, repairs, relines and rebases. Fixed: fixed bridges are not covered unless 1) required for replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise

General Coverage	Scope of Coverage	Level of Coverage
Emergency, Preventive and Routine Dental Care (continued)	Prosthodontics (continued)	Full complement of natural, functional and/or restored teeth; 2) required for cleft-palate stabilization; 3) required, as demonstrated by medical documentation, due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis. Space Maintenance: unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth. NOTE: Refer to the Medicaid Management Information System (MMIS) Dental Provider Manual for a more detailed description of services.

APPENDIX B

MANAGED CARE PLAN PREPAID BENEFIT PACKAGE

Covered Services	Managed Care Plan Scope of Benefit	Covered by Medicaid Fee-For-Service
Inpatient Hospital Services	Up to 365 medically necessary days per year (366 for leap year). Includes inpatient detoxification services provided in Article 28 hospitals for all Enrollees. Inpatient dental services are covered.	
Professional Ambulatory Services	Provided through ambulatory care facilities including hospital outpatient departments, D&T centers, and emergency rooms. Services include medical, surgical, preventive, primary , rehabilitative and, specialty care and, mental health, alcohol, family planning, and C/THP services. Covered as needed based on medical necessity. Ambulatory dental surgery is covered.	
Preventive Health Services	Care or service to avert disease/illness and/or its consequences. Preventive care includes primary care, secondary care and tertiary care. Coverage includes general health education classes, smoking cessation classes, childbirth education classes, parenting classes and nutrition counseling (with targeted outreach to persons with diabetes and pregnant women). HIV counseling and testing is a covered service for all Enrollees.	
Laboratory Services	Covered when medically necessary as ordered by a qualified medical professional, and when listed in the Medicaid fee schedule.	
Radiology Services	Covered when medically necessary as ordered by a qualified medical professional, and when ordered and provided by a qualified medical professional/practitioner.	
EPSDT Services/Child Teen Health Program (C/THP)	EPSDT is a package of early and periodic screening, including inter-periodic screens and, diagnostic and treatment services that are offered to all Medicaid eligible children under twenty-one (21) years of age known in New York State as the Child Teen Health Program C/THP.	Coverage for services not included in the managed care benefit package ordered by the child's physician based on the results of a screening.
Home Health Services	Home health care services include medically necessary nursing, home health aide services, equipment and appliances, physical therapy, speech/language pathology, occupational therapy, social work services or nutritional services provided by a home health care agency pursuant to an established care plan. Personal care tasks performed by a home health aide in connection with a home health care agency visit, and pursuant to an established care plan, are covered.	Coverage for services rendered by a personal care agency which are approved by the local social services district when ordered by the Enrollee's primary care provider (PCP). The district will determine the applicant's need for personal care agency services and coordinate with the personal care agency a plan of care.

Covered Services	Managed Care Plan Scope of Benefit	Covered by Medicaid Fee-For-Service
Private Duty Nursing Services	Covered service when medically necessary in accordance with the ordering physician, physician assistant or nurse practitioner's written treatment plan.	
Emergency Room Services	Covered for emergency conditions, medical or behavioral, the onset of which is sudden, manifesting itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment of such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person. Emergency services include health care procedures, treatments or services, including psychiatric stabilization and medical detoxification from drugs or alcohol that are provided for an emergency medical condition. A medical assessment (triage) is covered for non-emergent conditions.	
Foot Care Services	Foot care when the Enrollee's (any age) physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when performed as a necessary and integral part of otherwise covered services such as the diagnosis and treatment of diabetes, ulcers, and infections.	
Eye Care and Low Vision Services	Eye care includes the services of an optometrist and an ophthalmic dispenser and coverage for contact lenses, polycarbonate lenses, artificial eyes and replacement of lost or destroyed glasses (including repairs) when medically necessary Artificial eyes are covered as ordered by a Contractor's Participating Provider.	

Covered Services	Managed Care Plan Scope of Benefit	Covered by Medicaid Fee-For-Service
Durable Medical Equipment (DME)	DME are devices and equipment other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances. Covered when medically necessary as ordered by a Contractor's Participating Provider and procured from a participating provider. Coverage excludes disposable medical supplies and enteral formula.	Covered for excluded services, such as disposable supplies and enteral formula with a Provider's order.
Hearing Aids Services	Provided when medically necessary to alleviate disability caused by the loss or impairment of hearing. Hearing aid products include hearing aids, earmolds, special fittings, and replacement parts. Coverage excludes hearing aid batteries.	Covered for excluded services, such as hearing aid batteries with a Provider's order.
Family Planning and Reproductive Health Services ❑ Covered by Contractor ❑ Not Covered by Contractor	Family planning means the offering, arranging, and furnishing of those health services which enable individuals, including minors, who may be sexually active, to prevent or reduce the incidence of unintended pregnancies and includes the screening, diagnosis and treatment, as medically necessary, for sexually transmissible diseases, sterilization services and screening for pregnancy. Reproductive health services also includes all medically necessary abortions.	Enrollees may always obtain family planning and HIV testing and counseling services, when part of a family planning visit, outside of the Plan’s network from any provider that accepts Medicaid.

Covered Services	Managed Care Plan Scope of Benefit	Covered by Medicaid Fee-For-Service
Transportation Services Non-Emergency Transportation ❑ Covered by Contractor ❑ Not Covered by Contractor --- Emergency Transportation: ❑ Covered by Contractor ❑ Not Covered by Contractor	**Non-Emergency Transportation:** Transportation expenses are covered when transportation is essential in order for an Enrollee to obtain necessary medical care and services which are covered under this benefit package (or by fee-for-service Medicaid for carved-out services). Non-emergent transportation guidelines may be developed in conjunction with the LDSS, based on the LDSS' approved transportation plan. Transportation services means transportation by ambulance, ambulette or invalid coach, taxicab, livery, public transportation, or other means appropriate to the Enrollee's medical condition; and a transportation attendant to accompany the Enrollee, if necessary. Such services may include the transportation attendant's transportation, meals, lodging and salary; however, no salary will be paid to a transportation attendant who is a member of the Enrollee's family. For Enrollees with disabilities, the method of transportation must reasonably accommodate their needs, taking into account the severity and nature of the disability. --- **Emergency Transportation** Emergency transportation can only be provided by an ambulance service. Emergency transportation is covered for Enrollees suffering from severe, life-threatening or potentially disabling conditions which require the provision of emergency medical services while the Enrollee is being transported.	For MCOs that do not cover Transportation services, these services are paid for fee-for-service. Non-emergent transportation requests should be referred to the LDSS.
Dental Services ❑ Covered by Contractor ❑ Not Covered by Contractor	Optional benefit package dental services include: • Medically necessary preventive, prophylactic and other routine dental care, services and supplies and dental prosthetics required to alleviate a serious health condition, including one which affects employability; All Contractors must cover the following, even if dental services is not a Plan covered benefit: • Ambulatory or inpatient surgical services (subject to prior authorization by the Contractor). Coverage excludes the professional services of the dentist if dental services are not covered by the Contractor's benefit package.	Covered for routine exams, orthodontic services and appliances, dental office surgery, fillings, prophylaxis, provided to Enrollees of plans not electing to cover dental services. Orthodontic services are always covered by fee-for-service
Court-Ordered Services	Coverage includes such services ordered by a court of competent jurisdiction if the services are in the Contractor's benefit package.	

Covered Services	Managed Care Plan Scope of Benefit	Covered by Medicaid Fee-For-Service
Prosthetic/Orthotic Services/Orthopedic Footwear	Covered when medically necessary as ordered by the Contractor's Participating Provider.	
Mental Health Services	Covered when medically necessary, in accordance with the stop-loss provisions as described in Section 3 of this Agreement. Enrollees must be allowed to self refer for one mental health assessment from a Contractor's Participating Provider in a twelve (12) month period. In the case of children, such self referrals may originate at the request of a school guidance counselor or similar source.	Covered for all services in excess of 20 outpatient visits and 30 inpatient days (combined mental health and substance abuse) in accordance with the stop-loss provisions in Section 3 of this Agreement. Contractor continues to reimburse mental health service providers and coordinate care. The Contractor is reimbursed for payment through the stop-loss provisions.
Alcohol and Substance Abuse Services (ASA)	Covered when medically necessary in accordance with the stop-loss provisions as described in Section 3 of this Agreement. Enrollees must be allowed to self refer for one (1) assessment from a Contractor's Participating Provider in a 12 month period.	Covered for all services in excess of sixty (60) outpatient visits and thirty (30) inpatient days (combined mental health and substance abuse) in accordance with the stop-loss provisions in Section 3 of this Agreement . Contractor continues to reimburse ASA service providers and coordinate care. The Contractor is reimbursed for payment through the stop-loss provisions. Services ordered by the LDSS due to Welfare Reform (as indicated by “code 83”).
Experimental and/or Investigational Treatment	Covered on a case by case basis in accordance with the provisions of Section 4910 of theNew York State P.H.L.	
Detoxification Services	Coverage for medically necessary inpatient and outpatient services.	

I. PREPAID BENEFIT PACKAGE DEFINITIONS OF COVERED SERVICES

A. Medical Services

1. Inpatient Hospital Services

Inpatient hospital services, as medically necessary, shall include, except as otherwise specified, the care, treatment, maintenance and nursing services as may be required, on an inpatient hospital basis, up to 365 days per year (366 days in leap year). Among other services, inpatient hospital services encompass a full range of necessary diagnostic and therapeutic care including medical, surgical, nursing, radiological, and rehabilitative services. Services are provided under the direction of a physician, nurse practitioner, or dentist.

2. Professional Ambulatory Services

Outpatient hospital services are provided through ambulatory care facilities. Ambulatory care facilities include hospital outpatient departments (OPD), diagnostic and treatment centers (free standing clinics) and emergency rooms. These facilities may provide those necessary medical, surgical, and rehabilitative services and items authorized by their operating certificates. Outpatient services (clinic) also include preventive, primary medical, specialty, mental health, alcohol, C/THP and family planning services provided by ambulatory care facilities.

Hospital OPDs and D&T centers may perform ordered ambulatory services. The purpose of ordered ambulatory services is to make available to the Participating Provider those services needed to complement the provision of ambulatory care in his/her office. Examples are: diagnostic testing and radiology.

3. Physician Services

"Physicians' services," whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician:

(1) within the scope of practice of medicine or osteopathy as defined in law by the New York State Education Department; and
(2) by or under the personal supervision of an individual licensed and currently registered by the New York State Education Department to practice medicine or osteopathy.

Physician services include the full range of preventive care services, primary care medical services and physician specialty services that fall within a physician's scope of practice under New York State law.

The following are also included without limitations:

- pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit are covered.
- physical examinations, including those which are necessary for employment, school, and camp.
- physical and/or mental health, or alcohol and substance abuse examinations of children and their parents as requested by the LDSS to fulfill its statutory responsibilities for the protection of children and adults and for children in foster care.
- health and mental health assessments for the purpose of making recommendations regarding a recipient's disability status for Federal SSI applications .
- health assessments for the Infant /Child Assessment Program (ICHAP).
- annual preventive health visits for adolescents.
- new admission exams for school children if required by the LDSS.
- health screening, assessment and treatment of refugees, including completing SDOH/LDSS required forms.
- Child/Teen Health Program (C/THP) services which are comprehensive primary health care services provided to children under twenty-one (21) years of age (see Section 10 of this Agreement).

4. Home Health Services
18 NYCRR 505.23(a)3

Home health care services are provided to recipients in their homes by a home health agency certified under Article 36 of the New York State P.H.L. (Certified Home Health Agency – CHHA). Home health services mean the following services when prescribed by a provider and provided to a Medicaid managed care Enrollee in his or her home:

- nursing services provided on a part-time or intermittent basis by a CHHA or, if there is no CHHA that serves the county/district, by a registered professional nurse or a licensed practical nurse acting under the direction of the Enrollee’s PCP;

- physical therapy, occupational therapy, or speech pathology and audiology services; and

- home health services provided by a person who meets the training requirements of the SDOH, is assigned by a registered professional nurse to provide home health aid services in accordance with the Enrollee's plan of care, and is supervised by a registered professional nurse from a CHHA, or if the Contractor has no CHHA available a registered nurse, or therapist.

Personal care tasks performed by a home health aide incidental to a certified home health care agency visit, and pursuant to an established care plan, are covered.

Services include care rendered directly to the individual and instructions to his/her family or caretaker such as teacher or day care provider in the procedures necessary for the patient's treatment or maintenance.

The Contractor must provide up to two post partum home visits for high risk infants and/or high risk mothers, as well as to women with less than a forty-eight (48) hour hospital stay after a vaginal delivery or less than a ninety-six (96) hour stay after a cesarean delivery. Visits must be made by a qualified health professional (minimum qualifications being an RN with maternal/child health background), the first visit to occur within forty-eight (48) hours of discharge.

5. Private Duty Nursing Services

Private duty nursing services shall be provided by a person possessing a license and current registration from the NYS Education Department to practice as a registered professional nurse or licensed practical nurse. Private duty nursing services can be provided through an approved certified home health agency, a licensed home care agency, or a private practitioner. The location of nursing services may be in the individual's home or in the hospital.

Private duty nursing services are covered only when determined by the attending physician to be medically necessary. Nursing services may be intermittent, part-time or continuous and provided in accordance with the ordering physicians, or nurse practitioner's written treatment plan.

6. Emergency Room Services

Emergency conditions, medical or behavioral, the onset of which is sudden, manifesting itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment of such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person are covered. Emergency services include health care procedures, treatments or services, including psychiatric stabilization and medical detoxification from drugs or alcohol that are provided for an emergency medical condition. A medical assessment (triage) is covered for non-emergent conditions.

7. Services of Other Practitioners

a) Nurse Practitioner Services

Nurse practitioner services include preventive services, the diagnosis of illness and physical conditions, and the performance of therapeutic and corrective measures, within the scope of the nurse practitioner's licensure and collaborative practice agreement with a licensed physician in accordance with the requirements of the Department of Education.
The following services are also included in the nurse practitioner's scope of services, without limitation:

- Child/Teen Health Program(C/THP) services which are comprehensive primary health care services provided to children under 21 (see page 19 of this appendix and Section 10.5 of this Agreement);

- physical examinations including those which are necessary for employment, school and camp.

b. Rehabilitation Services
18 NYCRR 505.11

Rehabilitation services are provided for the maximum reduction of physical or mental disability and restoration of the recipient to his or her best functional level. Rehabilitation services include care and services rendered by physical therapists, speech-language pathologists and occupational therapists. Rehabilitation services may be provided in an Article 28 inpatient or outpatient facility, an Enrollee's home, in an approved home health agency, in the office of a qualified private practicing therapist or speech pathologist, or for a child in a school, pre-school or community setting, or in an RHCF for a short term

residency (i.e. duration of thirty (30) days or less). Rehabilitation services are covered as necessary, when ordered by the Contractor's Participating Provider.

c. Midwifery Services
SSA §1905 (a)(17), Education Law §6951(i).

Midwifery services include the management of normal pregnancy, childbirth and postpartum care as well as primary preventive reproductive health care to essentially healthy women as specified in a written practice agreement and shall include newborn evaluation, resuscitation and referral for infants. The care may be provided on an inpatient or outpatient basis including in a birthing center or in the recipient's home as appropriate. The midwife must be licensed by the State Education Department.

d. Clinical Psychological Services
18 NYCRR 505.18(a)

Clinical psychological services include psychological evaluation and testing and therapeutic treatment for personality or behavior disorders.

e. Foot Care Services

Covered services must include routine foot care when any Enrollee's (regardless of age) physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when performed as a necessary and integral part of otherwise covered services such as the diagnosis and treatment of diabetes, ulcers, and infections.
Services provided by a podiatrist for persons under 21 must be covered upon referral of a physician, physician's assistant, nurse practitioner or certified midwife.

Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of a pathological condition.

8. Eye Care and Low Vision Services
18 NYCRR §505.6(b)1-3

Eye care includes the services of optometrists and ophthalmic dispensers, and includes eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Eyecare

coverage includes the replacement of lost or destroyed eyeglasses. The replacement of the complete pair of eyeglasses should duplicate the original prescription and frames. Coverage also includes the repair or replacement of parts in situations where the damage is the result of causes other than defective workmanship. Replacement parts should duplicate the original prescription and frames. Repairs to and replacements of frames and/or lenses must be rendered as needed.

MCOs that allow upgrades of eyeglass frames or additional features, cannot apply the eyeglass benefit towards the cost and bill the difference to the Enrollee. However, if the Contractor does not include upgraded eyeglasses or additional features such as scratchcoating, progressive lenses, or photogray lenses, the Enrollee may choose to purchase the upgraded frame or feature by paying the entire cost as a private customer.

Examinations for diagnosis and treatment for visual defects and/or eye disease is provided only as necessary and as required by the individual's particular condition. Examinations which include refraction are limited to every two years unless otherwise justified as medically necessary.

Eyeglasses do not require changing more frequently than every two years unless medically indicated, such as a change in correction greater than ½ diopter, or unless the glasses are lost, damaged, or destroyed.

An ophthalmic dispenser fills the prescription of an optometrist or opthalmologist and supplies eyeglasses or other vision aids upon the order of a qualified practitioner.

Enrollees may self-refer to any participating provider of vision services (optometrist or opthalmologist) for refractive vision services.

9. Laboratory Services

18 NYCRR §505.7(a)

Laboratory services include medically necessary tests and procedures ordered by a qualified medical professional and listed in the Medicaid fee schedule for laboratory services.

All laboratory testing sites providing services under this contract must have a permit issued by the New York State Department of Health and a Clinical Laboratory Improvement Act (CLIA) certificate of waiver, a physician performed microscopy procedures (PPMP) certificate, or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver or a physician performed microscopy procedures (PPMP) certificate may perform only those specific tests

permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests for which they have been certified. Physicians providing laboratory testing may perform only those specific limited laboratory procedures identified in the Physician's MMIS Provider Manual.

10. Radiology Services

18 NYCRR§505.17(c)7,(d)

Radiology services include medically necessary services provided by qualified practitioners in the provision of diagnostic radiology, diagnostic ultrasound, nuclear medicine, radiation oncology, and magnetic resonance imaging (MRI). These services may only be performed upon the order of a qualified practitioner.

11. Early Periodic Screening Diagnosis and Treatment (EPSDT) Services Through the Child Teen Health Program (C/THP) And Adolescent Preventive Services

18 NYCRR §508.8

Child/Teen Health Program (C/THP) is a package of early and periodic screening, including inter-periodic screens and , diagnostic and treatment services that New York State offers all Medicaid eligible children under 21 years of age. Care and services shall be provided in accordance with the periodicity schedule and guidelines developed by the New York State Department of Health. The care includes necessary health care, diagnostic services, treatment and other measures (described in §1905(a) of the Social Security Act) to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services (regardless of whether the service is otherwise included in the New York State Medicaid Plan). The package of services includes administrative services designed to assist families obtain services for children that include outreach, education, appointment scheduling, administrative case management and transportation assistance.

12. Durable Medical Equipment (DME)

18 NYCRR §505.5(a)(1) and Section 4.4 of the MMIS DME, Medical and Surgical Supplies and Prosthetic and Orthotic Appliances Provider Manual.

Durable Medical Equipment (DME) are devices and equipment, other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances, and have the following characteristics:

(i) can withstand repeated use for a protracted period of time;

(ii) are primarily and customarily used for medical purposes;

(iii) are generally not useful to a person in the absence of illness or injury; and

(iv) are usually not fitted, designed or fashioned for a particular individual's use. Where equipment is intended for use by only one person, it may be either custom made or customized.

DME must be ordered by a qualified practitioner and procured from a participating provider.

13. Audiology, Hearing Aid Services and Products

18 NYCRR §505.31 (a)(1),(2) and Section 4.7 of the MMIS Hearing Aid Provider Manual

a) Hearing Aid Services and products are provided in compliance with Article 37 of the General Business Law when medically necessary to alleviate disability caused by the loss or impairment of hearing. Hearing aid services include: selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing of hearing aids, conformity evaluation, and hearing aid repairs.

b) Audiology services include audiometric examinations and testing, hearing aid evaluations and hearing aid prescriptions or recommendations, as medically indicated.

c) Hearing aid products include hearing aids, earmolds, special fittings, and replacement parts (Hearing aid batteries are excluded from the Benefit Package, but are covered by Medicaid fee-for-service as part of the Prescription benefit).

14. Preventive Care

Preventive care means care and services to avert disease/illness and/or its consequences. There are three levels of preventive care: 1) primary, such as immunizations, aimed at preventing disease; 2) secondary, such as disease screening programs aimed at early detection of disease; and 3) tertiary, such as physical therapy, aimed at restoring function after the disease has occurred. Commonly, the term "preventive care" is used to designate prevention and early detection programs rather than restorative programs.

The following preventive services are also included in the managed care benefit package. These preventive services are essential for promoting wellness and preventing illness. MCOs must offer the following :

- General health education classes.
- Pneumonia and influenza immunizations for at risk populations.
- Smoking cessation classes, with targeted outreach for adolescents and pregnant women.
- Childbirth education classes.

- Parenting classes covering topics such as bathing, feeding, injury prevention, sleeping, illness prevention, steps to follow in an emergency, growth and development, discipline, signs of illness, etc.
- Nutrition counseling, with targeted outreach for diabetics and pregnant women.
- Extended care coordination, as needed, for pregnant women.
- HIV Counseling and Testing.

15. Prosthetic/Orthotic Orthopedic Footwear

Section 4.5, 4.6 and 4.7 of the MMIS DME., Medical and Surgical Supplies and Prosthetic and Orthotic Appliances Provider Manual

a. Prosthetics are those appliances or devices ordered for an Enrollee by a Participating Provider which replace or perform the function of any missing part of the body. Artificial eyes are covered as part of the eye care benefit.

b. Orthotics are those appliances or devices, ordered for a recipient by a qualified practitioner which are used for the purpose of supporting a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body.

c. Orthopedic footwear means shoes, shoe modifications, or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot, or to form an integral part of a brace.

16. Experimental or Investigational Treatment

Experimental and investigational treatment is covered on a case by case basis.

Experimental or investigational treatment for life-threatening and/or disabling illnesses may also be considered for coverage under the external appeal process pursuant to the requirements of Section 4910 of New York State P.H.L. under the following conditions:

(1) The Enrollee has had coverage of a health care service denied on the basis that such service is experimental and investigational, and

(2) The Enrollee's attending physician has certified that the Enrollee has a life-threatening or disabling condition or disease

(a) for which standard health services or procedures have been ineffective or would be medically inappropriate, or

(b) for which there does not exist a more beneficial standard health service or procedure covered by the health care plan, or

(c) for which there exists a clinical trial, and

(3) The Enrollee's provider, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the Enrollee's life threatening or disabling condition or disease, must have recommended either

(a) a health service or procedure that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the Enrollee than any covered standard health service or procedure; or

(b) a clinical trial for which the Enrollee is eligible; and

(4) The specific health service or procedure recommended by the attending physician would otherwise be covered except for the MCO's determination that the health service or procedure is experimental or investigational.

B. Behavioral Health Services

These services include Alcohol and Substance Abuse Services and Mental Health Services. These services are covered by Medicaid fee-for-service for people who are in receipt of SSI or who are SSI related. However, inpatient detoxification services provided in an Article 28 hospital is a covered inpatient hospital benefit to be provided by the Contractor for all Enrollees up to 365 medically necessary days per year (366 days for leap years).

1. Alcohol and Substance Abuse Services

a. Inpatient Care

Inpatient alcoholism and substance abuse treatment and rehabilitation services involve a program of continuous twenty-four (24) hour care and services under medical direction for the treatment of alcoholism or substance abuse dependency or withdrawal. Services include, but are not limited to: assessment; management of detoxification and withdrawal conditions; group, individual or family counseling; alcohol and substance abuse education; rehabilitation; and discharge planning.

The Contractor is financially responsible for providing all inpatient alcohol and substance abuse treatment. The Contractor may provide the covered benefit through hospitals licensed pursuant to Article 28 of the New York State P.H.L.
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MCOs will be reimbursed for qualifying inpatient days of alcohol and substance abuse treatment beyond thirty (30) according to stop-loss provisions contained in Section 3.11 of this Agreement.

Inpatient detoxification in a hospital setting is considered an inpatient hospital benefit covered up to 365 medically necessary days per year (366 days for leap year). This service is also provided by the Contractor to SSI and SSI related Enrollees.

b. Outpatient Care

Outpatient Alcoholism/Substance Abuse Clinic Treatment Services: Outpatient alcoholism/substance abuse services involve a planned combination of multiple non-residential services provided to persons suffering from alcohol abuse or alcoholism or substance abuse or to their significant others under the supervision of a physician. Services include but are not limited to: assessment, individual, group, or family counseling, education, treatment planning, preventive counseling, discharge planning, and services to significant others. Services may be provided in facilities licensed by the Office of Alcoholism and Substance Abuse or by licensed individual practitioners. Enrollees must be allowed one self-referred alcohol/substance abuse assessment in a twelve (12)month period to a Contractor's Participating Provider.

2. Mental Health Services

a. Inpatient Services

The Contractor is financially responsible for providing all inpatient mental health services, including voluntary or involuntary admissions for mental health services. The Contractor will be compensated for clinically appropriate services provided in

excess of thirty (30) days according to stop-loss provisions contained in Section 3.11 of this Agreement. The Contractor may provide the covered benefit for medically necessary mental health inpatient services through hospitals licensed pursuant to Article 28 of the New York State P.H.L.

b. Outpatient Services

Include but are not limited to: assessment, stabilization, treatment planning, discharge planning, verbal therapies, and education, symptom management, case management services, crisis intervention and outreach services, chlozapine monitoring and collateral services as certified by OMH. Services may be provided in-home, office or the community. Services may be provided by licensed OMH providers or by other providers of mental health services including clinical psychologists, and physicians. For further information regarding service coverage consult the following MMIS Provider manuals: Clinic, Ambulatory Services for Mental Illness (Clinic Treatment Program), Clinical Psychology, and Physician (Psychiatric Services).

Enrollees must be allowed to self refer for one mental health assessment from a Contractor's Participating Provider in a twelve (12) month period. In the case of children, such self referrals may originate at the requestof a school guidance counselor or similar source.

C. Other Covered Services

1. Federally Qualified Health Center (FQHC) Services

FQHC services include physician services, services and supplies covered under SSA §1861 (s) (2) (A). Services include primary health, referral for supplemental health services, health education, patient case management, including outreach, counseling, referral and follow-up services (see 42 USC §254c(a) & (b)).

Prepaid Benefit Package
II. Optional Covered Services(at discretion of LDSS and/or Contractor)

A. Family Planning and Reproductive Health Care

Family Planning and Reproductive Health Care services means the offering, arranging and furnishing of those health services which enable individuals, including minors, who may be sexually active to prevent or reduce the incidence of unwanted pregnancy. These include: diagnosis and all medically necessary treatment, sterilization, screening and treatment for sexually transmissible diseases, screening for disease and pregnancy.

Also included is HIV counseling and testing when provided as part of a family planning visit. Additionally reproductive health care includes coverage of all medically necessary abortions. Elective induced abortions must be covered for New York City recipients. Fertility services are not covered.

If the Contractor excludes Family Planning from its benefit package, the Contractor is still required to provide the following services:

i) screening, related diagnosis, ambulatory treatment, and referral to participating provider as needed for dysmenorrhea, cervical cancer or other pelvic abnormality/pathology.
ii) screening, related diagnosis, and referral to participating provider for anemia, cervical cancer, glycosuria, proteinuria, hypertension, breast disease, pregnancy.

B. Dental Services

Dental care includes preventive, prophylactic and other routine dental care, services and supplies and dental prosthetics required to alleviate a serious health condition, including one which affects employability.

Dental surgery performed in an ambulatory or inpatient setting is the responsibility of the Contractor whether dental services are a covered plan benefit, or not. Inpatient claims and referred ambulatory claims for dental services provided in an inpatient or outpatient hospital setting for surgery, anesthesiology, X-rays, etc. are the responsibility of the Contractor. In these situations, the professional services of the dentist are covered by Medicaid fee-for-service. The Contractor should set up procedures to prior approve dental services provided in inpatient and ambulatory settings.

If Contractor's benefit package excludes dental services:

i) Enrollees may obtain routine exams, orthodontic services and appliances, dental office surgery, fillings, prophylaxis, and other Medicaid covered dental services from any qualified Medicaid provider who shall claim reimbursement from MMIS; and

ii) Inpatient and referred ambulatory claims for medical services provided in an inpatient or outpatient hospital setting in conjunction with a dental procedure (e.g. anesthesiology, X-rays), are the responsibility of the Contractor. In these situations, the professional services of the dentist are covered Medicaid fee-for-service.

C. Transportation Services

18 NYCRR §505.10

a. Non-Emergent Transportation

Transportation expenses are covered when transportation is essential in order for an Enrollee to obtain necessary medical care and services which are covered under the Medicaid program (either as part of the Contractor's benefit package or by fee-for-service Medicaid). Non-emergent transportation guidelines may be developed in conjunction with the LDSS, based on the LDSS' approved transportation plan.

Transportation services means transportation by ambulance, ambulette fixed wing or airplane transport, invalid coach, taxicab, livery, public transportation, or other means appropriate to the Enrollee's medical condition; and a transportation attendant to accompany the Enrollee, if necessary. Such services may include the transportation attendant's transportation, meals, lodging and salary; however, no salary will be paid to a transportation attendant who is a member of the Enrollee's family.

When the Contractor is capitated for non-emergency transportation, the Contractor is also responsible for providing transportation to Medicaid covered services that are not part of the Contractor's benefit package.

For Enrollees with disabilities, the method of transportation must reasonably accommodate their needs, taking into account the severity and nature of the disability.

b. Emergency Transportation

Emergency transportation can only be provided by an ambulance service including air ambulance service. Emergency ambulance transportation means the provision of ambulance transportation for the purpose of obtaining hospital services for an MA recipient who suffers from severe, life-threatening or potentially disabling conditions which require the provision of emergency medical services while the recipient is being transported.

Emergency medical services means the provision of initial urgent medical care including, but not limited to, the treatment of trauma, burns, and respiratory, circulatory and obstetrical emergencies.

Emergency ambulance transportation is transportation to a hospital emergency room generated by a "Dial 911" emergency system call or some other request for an immediate response to a medical emergency. Because of the urgency of the transportation request, insurance coverage or other billing provisions are not addressed until after the trip is completed. When the Contractor is capitated for this benefit, emergency transportation via 911 or any other emergency call system is a covered benefit and the Contractor is responsible for payment.

Prepaid Benefit Package
III Definitions of Non-Covered Services

The following services are excluded from the Contractor's benefit package, but are covered, in most instances, by Medicaid fee-for-service:

A. MEDICAL NON-COVERED SERVICES

1. Personal Care Agency Services

Personal care services are the provision of some or total assistance with personal hygiene, dressing and feeding; and nutritional and environmental support (meal preparation and housekeeping). Such services must be essential to the maintenance of the patient's health and safety in his or her own home. The service has to be ordered by a physician, and there has to be a medical need for the service. Licensed home care services agencies, as opposed to certified home health agencies, are the primary providers of personal care services. Recipients receiving PCS have to have a stable medical condition and are generally expected to be in receipt of such services for an extended period of time (years).

Services rendered by a personal care agency which are approved by the LDSS are not covered under the Benefit Package. Should it be medically necessary for the primary care provider (PCP) to order personal care agency services, the PCP (or the

Contractor on the physician's behalf) must first contact the Enrollee's LDSS contact person for personal care. The district will determine the applicant's need for personal care agency services and coordinate with the personal care agency a plan of care.

2. Residential Health Care Facilities (RHCF)

Individuals who are residents of RHCFs, are not covered for the Benefit Package services when the individual meets the requirements of an individual in permanent absence status under 18 NYCRR §360-1.4 (k). Short term residency (i.e., less than thirty (30) days) is a covered benefit.

3. Hospice Program

Hospice is a coordinated program of home and inpatient care that provides non-curative medical and support services for persons certified by a physician to be terminally ill with a life expectancy of six months or less. Hospice programs provide patients and families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement.

Hospices are organizations which must be certified under Article 40 of the NYS Public Health Law. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by federal and state requirements. All services must be provided according to a written plan of care which reflects the changing needs of the patient/family.

If an Enrollee in the Contractor's plan becomes terminally ill and receives Hospice Program services he or she may remain enrolled and continue to access the Contractor's benefit package while Hospice costs are paid for by Medicaid fee-for-service.

4. Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula

Coverage for drugs dispensed by community pharmacies, over the counter drugs, medical/surgical supplies and enteral formula are not included in the benefit package and will be paid for by Medicaid fee-for-service. Medical/surgical supplies are items other than drugs, prosthetic or orthotic appliances, or durable medical equipment which have been ordered by a qualified practitioner in the treatment of a specific medical condition and which are: consumable, non-reusable, disposable, or a specific rather than incidental purpose, and generally have no salvageable value (e.g. gauze pads, bandages and diapers). Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit are covered.

APPENDIX C

Can be accessed via the Internet at www.health.state.ny.us/nysdoh/mancare/main.htm

B. Non-Covered Behavioral Health Services

1. Alcohol and Substance Abuse Services

a. Methadone Maintenance Treatment Program (MMTP)

Consists of drug detoxification, drug dependence counseling, and rehabilitation services which include chemical management of the patient with methadone. Facilities that provide methadone maintenance treatment do so as their principal mission and are certified by the Office of Alcohol and Substance Abuse Services under 14 NYCRR, Part 1040.

b. Outpatient Substance Abuse Services Provided by Facilities Licensed Under Part 1035 of Mental Hygiene Law

Outpatient substance abuse services provided by facilities licensed by OASAS under 14 NYCRR Part 1035, Mental Hygiene Law, provide multiple non-residential services to persons suffering from substance abuse or dependence or to their significant others under the direction of a physician.

c. Outpatient Alcoholism Rehabilitation Services

Outpatient alcoholism rehabilitation programs provide full or half-day services to meet the needs of a specific target population. Most outpatient rehabilitation programs will have a separate, identifiable and specially designed environment and specific target population of chronic alcoholic persons who need a range of services which are different from those typically provided in an alcoholism outpatient clinic. These services are licensed by OASAS under 14 NYCRR, Part 380.3 or 380.8.

d. Alcohol and Substance Abuse (ASA) Services Ordered by the LDSS

The Contractor is not responsible for the provision and payment of ASA treatment services ordered by the LDSS and provided to Enrollees who have:

- been assessed as unable to work by the LDSS and are mandated to receive ASA services as a condition of eligibility for Public Assistance or Medicaid, or

- have been determined to be able to work with limitations (work limited) and are simultaneously mandated by the district into ASA treatment pursuant to work activity requirements.

The Contractor retains responsibility for the provision and payment of complicated inpatient detoxification services in Article 28 hospital settings.

If the Contractor is already providing ASA treatment and the LDSS is satisfied with the level of care and treatment plan, then the Contractor will continue to be responsible for the provision and payment of the services.

2. Mental Health Services

a. Intensive Psychiatric Rehabilitation Treatment Programs (IPRT)

A time limited active psychiatric rehabilitation designed to assist a patient in forming and achieving mutually agreed upon goals in living, learning, working and social environments, to intervene with psychiatric rehabilitative technologies to overcome functional disabilities. IPRT services are certified by OMH under 14 NYCRR, Part 587.

b. Day Treatment

A combination of diagnostic, treatment, and rehabilitative procedures which, through supervised and planned activities and extensive client-staff interaction, provides the services of the clinic treatment program, as well as social training, task and skill training and socialization activities. Services are expected to be of six months duration. These services are certified by OMH under 14 NYCRR, Part 587.

c. Continuing Day Treatment

Provides treatment designed to maintain or enhance current levels of functioning and skills, maintain community living, and develop self-awareness and self-esteem. Includes: assessment and treatment planning; discharge planning; medication therapy; medication education; case management; health screening and referral; rehabilitative readiness development; psychiatric rehabilitative readiness determination and referral; and symptom management. These services are certified by OMH under 14 NYCRR, Part 587.

d. Day Treatment Programs Serving Children

Day treatment programs are characterized by a blend of mental health and special education services provided in a fully integrated program. Typically these programs include: special education in small classes with an emphasis on individualized instruction, individual and group counseling, family services such as family counseling, support and education, crisis intervention, interpersonal skill development, behavior modification, art and music therapy.

e. Home and Community Based Services Waiver for Seriously Emotionally Disturbed Children

This waiver is in select counties for children and adolescents who would otherwise be admitted to an institutional setting if waiver services were not provided. The services include individualized care coordination, respite, family support, intensive in-home skill building, and crisis response.

f. Intensive Case Management (ICM)

The target population consists of individuals who are seriously and persistently mentally ill (SPMI), require intensive, personal and proactive intervention to help them obtain those services which will permit functioning in the community and either have symptomology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system.

Please note: See Generic definition of Comprehensive Medicaid Case Management (CMCM) under OTHER NON-COVERED SERVICES.

g. Partial Hospitalization

Provides active treatment designed to stabilize and ameliorate acute systems, serves as an alternative to inpatient hospitalization, or reduces the length of a hospital stay within a medically supervised program by providing the following: assessment and treatment planning; health screening and referral; symptom management; medication therapy; medication education; verbal therapy; case management; psychiatric rehabilitative readiness determination and referral; crisis intervention. These services are certified by OMH under NYCRR Part 587.

3. Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs, as follows:

a. OMH Licensed CRs*

Rehabilitative services in community residences are interventions, therapies and activities which are medically therapeutic and remedial in nature, and are medically necessary for the maximum reduction of functional and adaptive behavior defects associated with the person's mental illness.

b. Family-Based Treatment*

Rehabilitative services in family-based treatment programs are intended to provide treatment to seriously emotionally disturbed children and youth to promote their successful functioning and integration into the natural family, community, school or independent living situations. Such services are provided in consideration of a child's developmental stage. Those children determined eligible for admission are placed in surrogate family homes for care and treatment.

*These services are certified by OMH under 14 NYCRR Part 586.3.

c. Services Provided through OMH Designated Clinics For Children With Serious Emotional Disturbance (SED)

These are services provided to children and adolescents with serious emotional disturbance as defined in Section 1 of the Agreement, that will be provided by certain designated OMH clinics.

4. Mental Retardation and Developmental Disabilities Services

a. Long Term Therapy Services Provided by Article 16-Clinic Treatment Facilities or Article 28 Facilities

These services to persons with developmental disabilities include medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for a maximum reduction of the effects of physical or mental disability and restoration of the person to his or her best possible functional level. It also includes the fitting, training, and modification of assistive devices by licensed practitioners or trained others under their direct supervision. Such services are designed to ameliorate or limit the disabling condition and to allow the person to remain in or move to, the least restrictive residential and/or day setting. These services are certified by OMRDD under 14 NYCRR Part 679 (or they are provided by Article 28 Diagnostic and Treatment Centers that are explicitly designated by the SDOH as serving primarily persons with developmental disabilities.) If care of this nature is provided in facilities other than Article 28 or Article 16 centers, it is a covered service.

b. Day Treatment

A planned combination of diagnostic, treatment and rehabilitation services provided to developmentally disabled individuals in need of a broad range of services, but who do not need intensive 24 hour care and medical supervision. The services provided as identified in the comprehensive assessment may include nutrition, recreation, self-care, independent living, therapies, nursing, and transportation services. These services are generally provided in ICF or comparable setting. These services are certified by OMRDD under 14 NYCRR Part 690.

c. Comprehensive Medicaid Case Management (OMRDD)

The target population consists of individuals who are developmentally disabled, in need of ongoing and comprehensive rather than incidental case management and reside in OMRDD Certified Family Care Homes, Community Residences, live independently or with family or reside in residential facilities certified by a state agency other than OMRDD and are referred by the residential facility, or its supervising or certifying agency.

Please note: See generic definition of Comprehensive Medicaid Case Management (CMCM) under OTHER NON-COVERED SERVICES.

d. Home And Community Based Services Waivers

The Home and Community Based Waiver Program serves developmentally disabled persons who would otherwise be admitted to an ICF/MR if waivered services were not provided. The services provided include case management, respite, medical social counseling, nutrition counseling, respiratory therapy, and home adaptations. These services are authorized pursuant to a SSA Section 1915(b) waiver from DHHS.

e. Services Provided Through The Care At Home Program (OMRDD)

"Care At Home" waivers serve children who would not be eligible for Medicaid due to parents' income and resources and who are physically disabled according to SSI criteria and who are determined capable of being cared for at home if provided additional waivered services. These services are authorized pursuant to a SSA Section 1915(b) waiver from DHHS.

C. Other Non-Covered Services

1. The Early Intervention Program (EIP) – Children Birth to 2 Years

This program provides early intervention services to certain children, from birth through two years, who have a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. All managed care providers **must** refer infants and toddlers suspected of having a delay to the local designated Early Intervention agency in their area. (In most municipalities, the county health department is the designated agency, except: New York City - the Department of Health, Mental Retardation and Alcoholism Services; Erie County - The Department of Youth Services; Jefferson County - the Office of Community Services; and Ulster County - the Department of Social Services).

Early intervention services provided to this eligible population are categorized as Non-Covered. These services, which are designed to meet the developmental needs of the child and the needs of the family related to enhancing the child's development, will be identified on MMIS by unique rate codes by which only the designated early intervention agency can claim reimbursement. Contractor covered and authorized services will continue to be provided by the Contractor. Consequently, the Contractor will be expected to refer any enrolled child suspected of having a developmental delay to the locally designated early intervention agency in their area and participate in the development of the Child's Individualized Family Services Plan (IFSP). Contractor's participation in the development of the IFSP is necessary in order to coordinate the provision of early intervention services and services covered by the Contractor.

Additionally, the locally designated early intervention agencies will be instructed on how to identify a managed care recipient and the need to contact the Contractor to coordinate service provision.

2. Preschool Supportive Health Services – Children Three (3) through Four (4) Years

The Preschool Supportive Health Services Program (PSHSP) enables counties and New York City to obtain Medicaid reimbursement for certain educationally related medical services provided by approved preschool special education programs for young children with disabilities. The Committee on Preschool Special Education in each school district is responsible for the development of an Individualized Education Program (IEP) for each child evaluated in need of special education and medically related health services.

PSHSP services rendered to children three (3) through four (4) years of age in conjunction with an approved IEP are categorized as Non-Covered.

The PSHSP services will be identified on MMIS by unique rate codes through which only counties and New York City can claim reimbursement. In addition, a limited number of Article 28 Clinics associated with approved pre-school programs are allowed to directly bill Medicaid fee for service for these services. Contractor covered and authorized services will continue to be provided by the Contractor.

3. School Supportive Health Services – Children Five (5) through Twenty-One (21) Years of Age

The School Supportive Health Services Program (SSHSP) enables school districts to obtain Medicaid reimbursement for certain educationally related medical services provided by approved special education programs for children with disabilities. The Committee on Special Education in each school district is responsible for the development of an Individualized Education Program (IEP) for each child evaluated in need of special education and medically related services.

SSHSP services rendered to children five (5) through twenty-one (21) years of age in conjunction with an approved IEP are categorized as Non-Covered.

The SSHSP services are identified on MMIS by unique rate codes through which only school districts can claim Medicaid reimbursement. Contractor covered and authorized services will continue to be provided by the Contractor.

4. Comprehensive Medicaid Case Management (CMCM)

A program which provides "social work" case management referral services to a targeted population (e.g.: pregnant teens, mentally ill). A CMCM case manager will assist a client in accessing necessary services in accordance with goals contained in a written case management plan. CMCM programs do not provide services directly, but refer to a wide range of service providers. Some of these services are: medical, social psycho-social, education, employment, financial, and mental health. CMCM referral to community service agencies and/or medical providers requires the case manager to work out a mutually agreeable case coordination approach with the agency/medical providers. Consequently, if an Enrollee of the Contractor is participating in a CMCM program, the Contractor should work collaboratively with the CMCM case manager to coordinate the provision of services covered by the Contractor. CMCM programs will be instructed on how to identify a managed care recipient on EMEVS and informed on the need to contact the Contractor to coordinate service provision.

5. Directly Observed Therapy for Tuberculosis Disease

Tuberculosis directly observed therapy (TB/DOT) is the direct observation of oral ingestion of TB medications to assure patient compliance with the physician's prescribed medication regimen. While the clinical management of tuberculosis is covered in the Benefit Package, TB/DOT where applicable, can be billed directly to MMIS by any State Department of Health approved fee-for-service Medicaid TB/DOT provider. The Contractor remains responsible for communicating, cooperating and coordinating clinical management of TB with the TB/DOT provider.

6. AIDS Adult Day Health Care

Adult Day Health Care Programs (ADHCP) are programs designed to assist individuals with HIV disease to live more independently in the community or eliminate the need for residential health care services. Registrants in ADHCP require a greater range of comprehensive health care services than can be provided in any single setting, but do not require the level of services provided in a residential health care setting. Regulations require that a person enrolled in an ADHCP must require at least three hours of health care delivered on the basis of at least one visit per week. While health care services are broadly defined in this setting to include general medical care, nursing care, medication management, nutritional services, rehabilitative services, and substance abuse and mental health services, the latter two cannot be the sole reason for admission to the program. Admission criteria must include, at a minimum, the need for general medical care and nursing services.

7. HIV COBRA Case Management

The HIV COBRA (Community Follow-up Program) Case Management Program is a program that provides intensive, family-centered case management and community follow-up activities by case managers, case management technicians, and community follow-up workers. Reimbursement is through an hourly rate billable to Medicaid. Reimbursable activities include intake, assessment, reassessment, service plan development and implementation, monitoring, advocacy, crisis intervention, exit planning, and case specific supervisory review-case conferencing.

8. Fertility Services

Fertility services are not covered by the Benefit Package nor by Medicaid fee-for-service.